payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0064 Period: From 10/01/2016 To 09/30/2017 Worksheet S Parts I-III Date/Time Prepared: 2/26/2018 2: 20 pm

					/ 20/ 2010 2.	20 piii
PART I - COST	REPORT STATUS					
Provi der	1. [ X ] Electronically filed	cost report		Date: 2/26/2018	Ti me:	2: 20 p
use only	2. [ ] Manually submitted co	ost report				
	3. [ 0 ] If this is an amended 4. [ F ] Medicare Utilization.			esubmitted this cost	report	
Contractor use only	(1) As Submitted	6. Date Received: 7. Contractor No. 8. [ N ] Initial Report for 9. [ N ] Final Report for the	this Provider CCN 12. [	PR Date: ontractor's Vendor O ]If line 5, colu number of times	mn 1 is 4:	

## PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FAYETTE REGIONAL HEALTH SYSTEM (15-0064) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)	
	Officer or Administrator of Provider(s)
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	168, 146	-14, 710	0	-75, 797	1. 00
2.00	Subprovi der - I PF	0	23, 758	0		122, 973	2. 00
3.00	Subprovi der - I RF	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
200 00	Total	0	191 904	-14 710	0	47 176	200 00

Date

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0064 Peri od: Worksheet S-2 From 10/01/2016 Part I 09/30/2017 Date/Time Prepared: 2/26/2018 10:28 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1941 VIRGINIA AVE 1.00 PO Box: 1.00 Ci ty: CONNERSVI LLE State: IN 2.00 Zip Code: 47331 County: FAYETTE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed Number Number T, 0, or N) Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal FAYETTE REGIONAL HEALTH 150064 99915 07/01/1966 Ν Р 0 3.00 1 SYSTEM Р Subprovider - IPF FAYETTE REGIONAL HEALTH 15S064 99915 10/01/2013 0 4.00 4 Ν 4.00 SYSTEM 5.00 Subprovider - IRF FAYETTE REGIONAL HEALTH 15T064 99915 5 10/01/2003 Ν Ρ 0 5.00 SYSTEM 6.00 Subprovider - (Other) 6 00 Swing Beds - SNF FAYETTE REGIONAL HEALTH Р Р 7.00 15U064 99915 06/25/2009 N 7.00 SYSTEM 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11 00 Hospi tal -Based HHA FAYETTE MEMORIAL HOME 157097 99915 01/01/1984 12.00 Ρ Ν 12.00 HEALTH Separately Certified ASC 13.00 13.00 FMH HOME HEALTHCARE & 14.00 Hospi tal -Based Hospi ce 151548 99915 02/02/1996 14.00 HOSPI CF Hospital-Based Health Clinic - RHC 15.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2016 09/30/2017 20.00 21.00 Type of Control (see instructions) 2 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Υ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y' for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 Ν 22.01 Ν period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. Did this hospital receive a geographic reclassification from urban to rural as a result 22.03 Ν Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" for yes or used in the prior cost reporting period? In column 2, "N" for no. In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State Medi cai d State HMO days paid days eligible Medi cai d Medi cai d days paid days unpai d eligible unpai d days 1.00 2.00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 94 542 0 260 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

	i <u>al Systems</u> HOSPITAL HEALTH CARE CO	OMPLEX IDENTIFICATION [	REGIONAL HEA DATA	Provider CC	CN: 15-0064	Peri od:		Work	Form CMS- sheet S-2	
							30/2017	Date/Time Prep 2/26/2018 10:2		epare : 28 <i>a</i>
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medic HMO d	ays	Other Medicaid days	
00 If this	s provider is an IRF, e	nter the in-state	1.00	2.00	3. 00	4. 00	5. 0	0	6. 00	25.
Medi cai Medi cai out-of- Medi cai	d paid days in column d eligible unpaid days state Medicaid days in	1, the in-state s in column 2, n column 3, out-of-state s in column 4, Medicaid	e						-6.0	
							<u>kurai S</u> 00		of Geogr 2.00	H
cost re	eporting period. Enter	c classification (not many classification (not many classification (not many classification (not many classification)	or rural.	_			2	2		26. 27.
enter t	the effective date of t s is a sole community h	olumn 1, "1" for urban o the geographic reclassi nospital (SCH), enter t	fication in	column 2.			(	O		35
effect	in the cost reporting	peri od.				Begi n	ni na	Fr	ndi ng:	
						1.	00		2. 00	
		nd ending dates of SCH : and enter subsequent da		cript line	36 for number	er				36
00 If this	s is a Medicare depende	ent hospital (MDH), ent		r of period	ds MDH statu	S	(	0		37
is in effect in the cost reporting period.  37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in Naccordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see						37				
greater	e 37 is 1, enter the be	eginning and ending date s line for the number								38
jenter s	absequent dates.					Y,	/N		Y/N	
OO Door th	nic facility qualify fo	or the inpatient hospita	al navmant a	diustmont f	For Low volu		00 /		2. 00 Y	39
hospi ta for yes	als in accordance with s or "N" for no. Does t 2 CFR 412.101(b)(2)(i)	42 CFR §412. 101(b)(2)( the facility meet the m or (ii)? Enter in colu	i) or (ii)? ileage requi	Énter in co rements in	olumn 1 "Y" accordance				•	
"N" for	no in column 1, for d	the HAC program reduction discharges prior to October es on or after October	ober 1. Ente	r "Y" for y			N		N	40
							1. 0			-
	ctive Payment System (P									
with 42	2 CFR Section §412.320?	nd receive Capital paym ? (see instructions) ~ additional payment ex	•	•			N N	N N		45
Pt. III		f)? If yes, complete Wk				Ü	l N		N	
00 Is the Teachir	facility electing full ng Hospitals	42 CFR §412.300(b) PPS federal capital payme	nt? Enter "	Y" for yes	or "N" for	no.	N N	N		48
or "N"	for no.	n training residents in		. 0		,	N			57
GME pro is "Y" for yes	ograms trained at this did residents start tr s or "N" for no in colu	facility? Enter "Y" for facility? Enter "Y" for facining in the first more than 2. If column 2 is the facility and D-2, Pt.	or yes or "N nth of this "Y", complet	" for no ir cost report e Worksheet	n column 1. ing period?	If column Enter "Y				37
00 11 € 11:00		facility elect cost rei apter 21, §2148? If yes			ns' service	s as				58
		of Worksheet A? If y			Pt. I. NAHE 413.8 Y/N		neet A e #		-Through fi cati or	۱
defi ned								Cri te	rion Cod	е
defi ned					1. 00	2.	00		rion Cod	e

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC		eri od:	Worksheet S-2	
			F	rom 10/01/2016 o 09/30/2017		pared: 28 am
	Y/N	I ME	Direct GME	I ME	Direct GME	20 4111
	1. 00	2. 00	3. 00	4. 00	5. 00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61. 01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61. 02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61. 03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00			61. 04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61. 05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00				61. 06
	Pr	ogram Name	Program Code	Unwei ghted IME FTE Count	Unweighted Direct GME FTE Count	
The second secon		1. 00	2. 00	3.00	4.00	
<ul> <li>61. 10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> <li>61. 20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> </ul>				0.00		61. 10
	'			•		
ACA Provisions Afforting the Health Possuress and So	rvi coc	Admi ni strati an	(UDCA)		1.00	
ACA Provisions Affecting the Health Resources and Se 62.00 Enter the number of FTE residents that your hospital	trai ne	d in this cost	reportina peri	od for which	0.00	62. 00
your hospital received HRSA PCRE funding (see instruction of the first state of the first	ctions) a Teach gram. (:	ing Health Cent see instruction	er (THC) into			62. 01
Teaching Hospitals that Claim Residents in Nonprovid 63.00 Has your facility trained residents in nonprovider so "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co			N	63. 00
The second of th	210 1111	es of through	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te 1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in N						
period that begins on or after July 1, 2009 and befo 64.00 Enter in column 1, if line 63 is yes, or your facili- in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	re June ty trai n-prima all no d non-p n colum	e 30, 2010.  ned residents ry care nprovider rimary care n 3 the ratio	0.00			64. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0064 Peri od: Worksheet S-2 From 10/01/2016 Part I 09/30/2017 Date/Time Prepared: 2/26/2018 10:28 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν O N 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.  108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N  CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					108. 00
	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3. 00	4. 00	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	· N	N	N	N	109. 00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter				N	110. 00

complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as

appl i cabl e.

are claimed, enter in column 2 the home office chain number. (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA From 10/01/2016 Part I 09/30/2017 Date/Time Prepared: 2/26/2018 10:28 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143. 00 Ci ty: 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 γ 1. 00 2.00 145.00|If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145 00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν N 148 00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no N 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9. 99169. 00 transition factor. (see instructions) Begi nni ng Endi ng 1. 00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 10/01/2016 09/30/2017 170. 00 period respectively (mm/dd/yyyy) 1.00 2.00 171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in 0171.00 N section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	Υ	12/13/2017	Υ	12/13/2017	16. 00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	N		N		17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
40.00	cost report? If yes, see instructions.					40.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R	IN .		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					l

Health Financial Systems FAYETTI HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION		Provider C	N: 15-0064	In Lie	worksheet S	
TIOSITINE NINE TIOSITINE TEACHT ONCE RETAINDURGEMENT QUESTION	WWW INC	Trovider c	ON. 15 0004	From 10/01/2016 To 09/30/2017		repared:
			i pti on	Y/N	Y/N	
20 00 16 1: 1/ 17 :	DC a D		0	1.00	3.00	20.00
20.00 If line 16 or 17 is yes, were adjustments made to Report data for Other? Describe the other adjustm				N	N	20.00
moport data for other. Beserve the other day astim	orts.	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21.00 Was the cost report prepared only using the province records? If yes, see instructions.	der's	N		N		21. 00
					1. 00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS (	ONLY (EXCE	PT CHILDRENS H	lOSPI TALS)		1.00	
Capital Related Cost	•		Í			
22.00 Have assets been relifed for Medicare purposes? I					N	22. 00
23.00 Have changes occurred in the Medicare depreciation	n expense	due to apprais	sals made dur	ing the cost	N	23. 00
reporting period? If yes, see instructions.  24.00 Were new leases and/or amendments to existing lea	ses entere	ed into during	this cost re	porting period?	N	24. 00
If yes, see instructions		J				
25.00 Have there been new capitalized leases entered in	to during	the cost repor	ting period?	'If yes, see	Y	25. 00
instructions.  26.00 Were assets subject to Sec. 2314 of DEFRA acquired instructions.	during th	ne cost reporti	ng period? I	f yes, see	N	26. 00
27.00 Has the provider's capitalization policy changed	during the	e cost reportir	ng period? If	yes, submit	N	27. 00
copy.						
28.00 Were new loans, mortgage agreements or letters of						
29.00 Did the provider have a funded depreciation account						
treated as a funded depreciation account? If yes, see instructions  100 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see						30. 00
	, , , , , , , , , , , , , , , , , , ,					
Purchased Servi ces						
32.00 Have changes or new agreements occurred in patien arrangements with suppliers of services? If yes,			ed through co	ntractual	N	32. 00
33.00 If line 32 is yes, were the requirements of Sec.			ng to competi	tive bidding? If	N	33. 00
Provi der-Based Physi ci ans						
34.00 Are services furnished at the provider facility u	nder an ar	rangement with	n provi der-ba	sed physicians?	Y	34.00
35.00 If line 34 is yes, were there new agreements or all physicians during the cost reporting period? If yes			nts with the	provi der-based		35. 00
physicians during the cost reporting period: if y	es, see m	istructions.		Y/N	Date	
				1.00	2. 00	
Home Office Costs	2			A.I		9, 65
36.00 Were home office costs claimed on the cost report 37.00 If line 36 is yes, has a home office cost stateme		renared by the	home office?	N N		36. 00 37. 00
If yes, see instructions.	iir been bi	cpared by the	nome office?	IN		37.00
38.00 If line 36 is yes, was the fiscal year end of the the provider? If yes, enter in column 2 the fiscal	e home off I year end	fice different d of the home o	from that of office.	N		38. 00
39.00 If line 36 is yes, did the provider render service see instructions.				s, N		39. 00
40.00 If line 36 is yes, did the provider render service instructions.	es to the	home office?	If yes, see	N		40. 00
Cost Report Preparer Contact Information		1.	00	2.	00	
41.00 Enter the first name, last name and the title/pos held by the cost report preparer in columns 1, 2,		KYLE		41. 00		
respectively. 42.00 Enter the employer/company name of the cost repor	t	BLUE AND CO				42. 00
preparer.	ho oo-+	217 712 7057		VCCMI TUODI UE AN	DCO COM	42.00
43.00 Enter the telephone number and email address of the report preparer in columns 1 and 2, respectively.	ne cost	317. 713. 7957		KCSMI TH@BLUEAN	DCO. COM	43.00

Heal th	Financial Systems FAYETTE REGI	ONAL	HEALTH SYSTEM	In Li€	eu of Form CMS-	2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0064	Peri od: From 10/01/2016	Worksheet S-2 Part II	
				To 09/30/2017		pared: 28 am
			3. 00			
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the title/position	S	SENI OR MANAGER			41.00
	held by the cost report preparer in columns 1, 2, and	3,				
	respectively.					
42. 00	Enter the employer/company name of the cost report					42. 00
	preparer.					
43.00	Enter the telephone number and email address of the co	st				43.00
	report preparer in columns 1 and 2, respectively.					

| Peri od: | Worksheet S-3 | From 10/01/2016 | Part | | Part | To 09/30/2017 | Date/Time Prepared: Health Financial Systems FAYETTE REHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0064

				To	09/30/2017	Date/Time Pre	
						2/26/2018 10:   I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	Component	Li ne Number	No. or beas	Avai I abl e	CAIT HOURS	little v	
		1.00	2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		25		0.00		1. 00
	8 exclude Swing Bed, Observation Bed and	00.00		7, 120	0.00		
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		25	9, 125	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	20	7, 300	0.00	0	8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		45	16, 425	0.00	0	14. 00
15. 00	CAH visits					0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00		4, 380		0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00	C	0		0	17. 00
18. 00	SUBPROVI DER	42. 00	C	0		0	
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	101. 00				0	
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE	116. 00	C	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	
27. 00	Total (sum of lines 14-26)		57	'		_	27. 00
28. 00	Observation Bed Days					0	
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		C	0			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days						33.00
33. UT	LTCH site neutral days and discharges	1					33. 01

Provider CCN: 15-0064

						2/26/2018 10:	28 am
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	835	68	1, 763			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)		770				0.00
2.00	HMO and other (see instructions)	0	772				2.00
3.00	HMO I PF Subprovi der	0	0				3.00
4.00	HMO I RF Subprovi der	0	0	,			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	(			5. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF	835	0 68	1 7/3			6. 00 7. 00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	835	08	1, 763			7.00
8. 00	INTENSIVE CARE UNIT	169	0	271			8.00
9. 00	CORONARY CARE UNIT	107	O	271			9.00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY		24	324			13. 00
14. 00	Total (see instructions)	1, 004	92	2, 358		321. 35	
15. 00	CAH visits	0	0	2,000		021100	15. 00
16. 00	SUBPROVIDER - IPF	1, 585	195	2, 242	0.00	5. 09	
17. 00	SUBPROVI DER - I RF	o	0	, (	0.00	10. 29	1
18. 00	SUBPROVI DER		0	Ċ		l e	
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	143	0	390	0.00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0	0	C	0.00	0.00	24. 00
24. 10	HOSPICE (non-distinct part)	0	0	C	)		24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C			
27. 00					0.00	336. 73	
28. 00	3		0	491			28. 00
29. 00	Ambul ance Tri ps	0		_			29. 00
30.00				C			30.00
31. 00	1 1 3			(			31.00
32.00	3 3 1	0	32	41			32.00
32. 01	Total ancillary labor & delivery room			(	1		32. 01
33. 00	outpatient days (see instructions)	0					33. 00
	LTCH non-covered days LTCH site neutral days and discharges						33. 00
55.01	TETOT SI LE HEULT di days alla di schai ges	ı Y			1	I	1 33.01

| Period: | Worksheet S-3 | From 10/01/2016 | Part | To 09/30/2017 | Date/Time Prepared: Provider CCN: 15-0064

					То	09/30/2017	Date/Time Pre 2/26/2018 10:	
		Full Time			Di scha	arges	, =. =0, =0,	
	Component	Equi val ents Nonpai d	Title V	Т	Title XVIII	Title XIX	Total All	
	30p3/10/11	Workers					Pati ents	
		11.00	12. 00		13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and			0	292	34	688	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)			ŀ	0	214		2. 00
3.00	HMO I PF Subprovi der					0		3. 00
4.00	HMO I RF Subprovi der			ł		U		4.00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF							5. 00 6. 00
7. 00	Total Adults and Peds. (exclude observation			ł				7. 00
7.00	beds) (see instructions)							7.00
8.00	INTENSIVE CARE UNIT			ı				8. 00
9. 00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT			ı				10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)			ı				12.00
13.00	NURSERY			ı				13.00
14.00	Total (see instructions)	0. 00		0	292	34	688	14.00
15.00	CAH visits							15. 00
16.00	SUBPROVI DER - I PF	0.00		0	119	29	187	16. 00
17. 00	SUBPROVI DER - I RF	0. 00		0	0	0	0	17. 00
18. 00	SUBPROVI DER	0. 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	0. 00		ŀ				22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00						23. 00
24. 00	HOSPICE	0.00		ı				24. 00 24. 10
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC			ı				25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00		ł				26. 25
27. 00	Total (sum of lines 14-26)	0.00						27. 00
28. 00	Observation Bed Days	0.00		ı				28. 00
29. 00	Ambulance 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)							32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days				0			33. 00
33. 01	LTCH site neutral days and discharges				0			33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0064

| Peri od: | Worksheet S-3 | From 10/01/2016 | Part II | To 09/30/2017 | Date/Time Prepared: | Date/Time Prepared: | Part II | P

					To	09/30/2017	Date/Time Prep 2/26/2018 10:2	
		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries (from Wkst.	Sal ari es (col. 2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col. 4	r	
	PART II - WAGE DATA	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	SALARI ES							
1.00	Total salaries (see instructions)	200. 00	18, 986, 095	0	18, 986, 095	768, 462. 00	24. 71	1. 00
2.00	Non-physician anesthetist Part		0	О	0	0.00	0. 00	2. 00
3. 00	A   Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
	В		0					
4. 00	Physician-Part A - Administrative		291, 926	0	291, 926	1, 632. 00	178. 88	4. 00
4. 01	Physicians - Part A - Teaching		0	0	·	0.00	0. 00	
5.00	Physician and Non Physician-Part B		3, 152, 345	0	3, 152, 345	25, 019. 00	126. 00	5. 00
6.00	Non-physician-Part B for		0	0	0	0.00	0. 00	6. 00
	hospital-based RHC and FQHC services							
7. 00	Interns & residents (in an	21. 00	0	О	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0	0	0	0. 00	0. 00	7. 01
7.01	residents (in an approved		0			0.00	0.00	7.01
8. 00	programs) Home office and/or related		0	0	0	0. 00	0. 00	8. 00
	organization personnel		0		Ĭ			
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 3, 106, 699	0 46, 192	0 3, 152, 891	0. 00 146, 863. 00	0. 00 21. 47	9. 00 10. 00
	instructions)			10, 172	5, 152, 57.	. 10, 000. 00	2	
11. 00	OTHER WAGES & RELATED COSTS  Contract labor: Direct Patient		597, 975	0	597, 975	7, 415. 00	80 64	11. 00
	Care					·		
12. 00	Contract Labor: Top Level management and other		0	0	0	0. 00	0.00	12. 00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		577, 119	0	577, 119	5, 159. 00	111. 87	13. 00
	A - Administrative							
14. 00	Home office and/or related orgainzation salaries and		0	0	0	0. 00	0.00	14. 00
	wage-related costs							
14. 01 14. 02	Home office salaries Related organization salaries		0	0	0	0. 00 0. 00		14. 01 14. 02
15. 00	Home office: Physician Part A		0	o	0	0. 00		15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0. 00	0. 00	16. 00
	Physicians Part A - Teaching							
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		2, 959, 533	0	2, 959, 533			17. 00
10.00	instructions)		154 451		154 451			10.00
18. 00	Wage-related costs (other) (see instructions)		154, 451	0	154, 451			18. 00
19.00	Excluded areas		748, 062	0				19.00
20. 00	Non-physician anesthetist Part A		Ü	0	0			20. 00
21. 00	Non-physician anesthetist Part		0	0	O			21. 00
22. 00	Physician Part A -		26, 264	0	26, 264			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0				22. 01
23. 00	Physician Part B		309, 692		309, 692			23.00
24. 00 25. 00	Wage-related costs (RHC/FQHC)		0	0	0			24. 00 25. 00
	approved program)		0	Ĭ				
25. 50	Home office wage-related (core)		0	0	0			25. 50
25. 51	Related organization		0	0	О			25. 51
25. 52	wage-related (core) Home office: Physician Part A		0	0				25. 52
20.02	- Administrative -		0	<b> </b>				20.02
25. 53	wage-related (core) Home office & Contract		n	o	0			25. 53
2.00	Physicians Part A - Teaching -		0					50
	wage-related (core)  OVERHEAD COSTS - DIRECT SALARIE	ES						
26. 00	Employee Benefits Department	4. 00	144, 174	l				26.00
27. 00	Administrative & General	5. 00	2, 146, 773	-614, 302	1, 532, 471	84, 281. 00	18. 18	27. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0064

							2/26/2018 10:	28 am_
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		1, 321, 179	0	1, 321, 179	26, 021. 00	50. 77	28.00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7. 00	270, 678	10, 886	281, 564	13, 609. 00	20. 69	30.00
31.00	Laundry & Linen Service	8. 00	0	0	0	0.00	0.00	31.00
32.00	Housekeepi ng	9. 00	516, 249	23, 239	539, 488	47, 731. 00	11. 30	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10. 00	531, 412	-291, 719	239, 693	17, 610. 00	13. 61	34.00
35.00	Di etary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	314, 661	314, 661	21, 475. 00	14. 65	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13. 00	697, 039	14, 624	711, 663	18, 830. 00	37. 79	38.00
39.00	Central Services and Supply	14. 00	71, 358	3, 662	75, 020	5, 132. 00	14. 62	39.00
40.00	Pharmacy	15. 00	312, 276	5, 914	318, 190	10, 406. 00	30. 58	40.00
41.00	Medical Records & Medical	16. 00	674, 272	74, 380	748, 652	32, 017. 00	23. 38	41.00
	Records Library				·			
42.00	Social Service	17. 00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

| Peri od: | Worksheet S-3 | From 10/01/2016 | Part III | To 09/30/2017 | Date/Time Prepared: | Date/Time Prep Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0064

						077 007 2017	2/26/2018 10: 2	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		17, 154, 929	0	17, 154, 929	769, 464. 00	22. 29	1.00
	instructions)							
2.00	Excluded area salaries (see		3, 106, 699	46, 192	3, 152, 891	146, 863. 00	21. 47	2.00
	instructions)							
3.00	Subtotal salaries (line 1		14, 048, 230	-46, 192	14, 002, 038	622, 601. 00	22. 49	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 175, 094	0	1, 175, 094	12, 574. 00	93. 45	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		3, 140, 248	0	3, 140, 248	0. 00	22. 43	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		18, 363, 572	-46, 192	18, 317, 380	635, 175. 00	28. 84	6. 00
7.00	Total overhead cost (see		6, 685, 410	-290, 335	6, 395, 075	284, 697. 00	22. 46	7.00
	instructions)							

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-1		
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0064	Period: Worksheet S-3 From 10/01/2016 Part IV		

	To 09/30/2017	Date/Time Prep 2/26/2018 10:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	-10, 861	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2, 896, 267	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9. 00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	-86, 801	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	-62, 224	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	-97, 874	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	60, 339	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	1, 335, 343	17.00
18. 00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unempl oyment Insurance	9, 362	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))	0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	4, 043, 551	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER	154, 451	25. 00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu	of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0064	From 10/01/2016 To 09/30/2017	Worksheet S-3 Part V Date/Time Prepared:

		10 09/30/201/	2/26/2018 10:2	
	Cost Center Description	Contract Labor		20 (111
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	597, 975	4, 043, 551	1.00
2.00	Hospi tal	597, 975	4, 043, 551	2. 00
3.00	Subprovi der - I PF	0	0	3. 00
4.00	Subprovi der - I RF	0	0	4. 00
5. 00	Subprovi der - (Other)	0	0	5. 00
6. 00	Swing Beds - SNF	0	0	6. 00
7. 00	Swing Beds - NF	0	0	7. 00
8. 00	Hospi tal -Based SNF			8. 00
9. 00	Hospi tal -Based NF			9. 00
10. 00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA	0	0	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			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16. 00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis			17.00
18. 00	Other	0	0	18. 00

Heal th	Financial Systems F/	AYETTE REGIONAL	HEALTH SYSTEM		In lie	eu of Form CMS-:	2552-10
	IEALTH AGENCY STATISTICAL DATA	WELLE KEGLOWIE	Provi der C		Peri od: From 10/01/2016	Worksheet S-4	
			Component	CCN: 15-7097	To 09/30/2017		
					Home Health	PPS	20 alli _
					Agency I		
0.00	Country					00	0.00
0.00	County	Title V	Title XVIII	Title XIX	FAYETTE Other	Total	0.00
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2. 00	3.00	4. 00	5. 00	
1.00	Home Health Aide Hours	0	11	1	0 0		1. 00
2.00	Unduplicated Census Count (see instructions)	0. 00	9. 00		0.00 ployees (Full Ti		2. 00
					, .,		
		Enter the number		Staff	Contract	Total	
		Joan Herman	mornt moont				
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0		1. 00	2. 00	3. 00	
3.00	Administrator and Assistant Administrator(s)		40.00	1		l .	3.00
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.0		l .	
6.00	Direct Nursing Service			0.0	0.00	0.00	6. 00
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0.0			
9.00	Physi cal Therapy Supervisor			0.0			1
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			0.0			1
12.00	Speech Pathology Service			0.0			1
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0.0			1
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0.0			1
17. 00	Home Health Aide Supervisor			0.0			
18. 00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0.0	0.00	0.00	18. 00
19. 00	Enter in column 1 the number of CBSAs where				2		19. 00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced			17140			20. 00
	during this cost reporting period (line 20 contains the first code).						
20. 01		Full Ep	i sodes	99915			20. 01
		Wi thout	With Outliers	LUPA Epi sode		Total (cols.	
		Outliers 1.00	2. 00	3.00	Epi sodes 4. 00	1-4) 5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	22	0		1 28	51	21. 00
22. 00	Skilled Nursing Visit Charges	2, 794	0	1:	27 3, 556	l .	22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	12 1, 656	0	1	0 276	14 1, 932	1
25. 00	Occupational Therapy Visits	19	0		0 3	22	25. 00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	2, 622	0	1	0 414	1	1
28. 00	Speech Pathology Visit Charges	o	0		0 0	0	28. 00
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	0	0	1	0 0	0	1
31.00	Home Health Aide Visits	32	0		0 24	56	31. 00
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	2, 432 85	0	l .	0 1, 824 1 57		1
	29, and 31)						
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	9, 504	0	l .	0 0 27 6, 070	0 15, 701	34. 00 35. 00
36. 00	30, 32, and 34)	4			1 6		36. 00
	outlier)						
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	138	0		13 114	0 295	37. 00 38. 00
				•	•	•	•

Heal th	Financial Systems	F.A	AYETTE REGIONAL	. HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
	HOSPITAL-BASED HOSPICE I DENTIFICATION DATA Provider CCN: 15-0064 Period: Worksheet S-9							
						From 10/01/2016	PARTS I THROU	GH IV
	Hospi ce CCN: 15-1548   To 09/30/2017   [							pared:
						Hospi ce I	2/26/2018 10:	28 am
		Unduplicated				поѕргсе г		
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng	7 0 (1.10)	col s. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility			,	
		1. 00	2.00	3.00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	ST REPORTING F	PERI ODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
1.00	Hospice Continuous Home Care							1. 00
2.00	Hospice Routine Home Care							2. 00
3.00	Hospice Inpatient Respite Care							3. 00
4.00	Hospice General Inpatient Care							4. 00
5.00	Total Hospice Days							5. 00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
6.00	Number of patients receiving							6. 00
7.00	hospice care							7.00
7. 00	Total number of unduplicated							7. 00
	Continuous Care hours billable to Medicare							
8. 00	Average Length of Stay (line 5							8. 00
0.00	/ line 6)							0.00
9. 00	Unduplicated census count							9. 00
	Parts I and II, columns 1 and 2	also include	the days renor:	ted in columns	3 and 4			71.00
MOTE.	rarts rand rr, corumns rand z	ar so Ther due						
				Title XVIII	Title XIX	0ther	Total (sum of	
							col s. 1	
				1.00	0.00	0.00	through 3)	
	DADT III ENDOLIMENT DAVC FOR	COCT DEDODTI NO	DEDLODE DECLA	1.00	2.00	3. 00 . 2015	4. 00	
10. 00	PART III - ENROLLMENT DAYS FOR Hospice Continuous Home Care	COST REPORTING	PERIODS BEGIN	INTING ON OR AFT	ER OCTOBER I	, 2015	0	10.00
11. 00	Hospice Continuous Home Care					0 36	36	
12. 00	Hospice Inpatient Respite Care					0 0	0	12. 00
	Hospice General Inpatient Care					0 0	0	
						0 36		
14.00	PART IV - CONTRACTED STATISTICA	I DATA FOR COS	ST REPORTING PE	RIODS BEGINNIN	G ON OR AFTE			14.00
15. 00	Hospice Inpatient Respite Care	5/11/1 1 010 000	El Ollino I L	0		0 0	0	15. 00
	Hospice General Inpatient Care				l .	0 0	_	
	install a series and a series and			1	ı	-1	ĭ	

Heal th	Financial Systems FAYETTE REGIONAL	HEALTH SYSTEM		In Lie	eu of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CO		Peri od:	Worksheet S-1	
				From 10/01/2016 To 09/30/2017	Date/Time Pre	narod:
				10 04/30/201/	2/26/2018 10:	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3	divided by li	ne 202 column	8)	0. 346528	1.00
	Medicaid (see instructions for each line)					
2. 00 3. 00	Net revenue from Medicaid				4, 864, 633 Y	2. 00 3. 00
4. 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supple		s from Medica	i d2	ĭ	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payment	, ,		14:	4, 187, 799	ł
6.00	Medi cai d charges				21, 395, 760	1
7.00	Medicaid cost (line 1 times line 6)				7, 414, 230	7. 00
8.00	Difference between net revenue and costs for Medicaid progr	am (line 7 min	us sum of lin	es 2 and 5; if	0	8. 00
	<pre>&lt; zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions)</pre>	a fan aaah lin	2)			
9. 00	Net revenue from stand-alone CHIP	s for each fin	e)		4, 863	9. 00
10. 00	Stand-alone CHIP charges				4, 863	•
11. 00	Stand-alone CHIP cost (line 1 times line 10)				1, 685	1
12.00	Difference between net revenue and costs for stand-alone CH	IP (line 11 mi	nus line 9; i	f < zero then	0	12. 00
	enter zero)					
12.00	Other state or local government indigent care program (see			`		12.00
13. 00 14. 00	Net revenue from state or local indigent care program (Not Charges for patients covered under state or local indigent			,	0	
14.00	10)	care program (	Not Theradea	III IIIles 0 01	0	14.00
15. 00	State or local indigent care program cost (line 1 times lin	e 14)			0	15. 00
16.00	Difference between net revenue and costs for state or local		program (lin	e 15 minus line	0	16. 00
	13; if < zero then enter zero)	0.11.5			L ,	
	Grants, donations and total unreimbursed cost for Medicaid, instructions for each line)	CHIP and state	e/Local Indig	ent care progra	ms (see	
17. 00	Private grants, donations, or endowment income restricted t	o funding char	ity care		0	17. 00
18. 00	Government grants, appropriations or transfers for support				0	
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and I 8, 12 and 16)	ocal indigent	care programs	(sum of lines	0	19. 00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col . 2)	
	Uncompared Cara (see instructions for each line)		1. 00	2. 00	3. 00	
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire	facility	1, 017, 60	5 0	1, 017, 605	20 00
20.00	(see instructions)	raciiity	1,017,00		1,017,000	20.00
21. 00	Cost of patients approved for charity care and uninsured di	scounts (see	352, 62	9 0	352, 629	21. 00
	instructions)					
22. 00	Payments received from patients for amounts previously writ	ten off as		0	0	22. 00
23. 00	charity care Cost of charity care (line 21 minus line 22)		352, 62	9 0	352, 629	23. 00
					1.00	
24 00	Does the amount on line 20 column 2, include charges for pa	tient days hev	ond a Length	of stay limit	1.00	24. 00
24.00	imposed on patients covered by Medicaid or other indigent c		ond a rength	or stay iriii t		24.00
25. 00	If line 24 is yes, enter the charges for patient days beyon stay limit		care program	's length of	0	25. 00
26. 00	Total bad debt expense for the entire hospital complex (see	instructions)			2, 004, 078	26. 00
27. 00	Medicare reimbursable bad debts for the entire hospital com				169, 012	27. 00
27. 01	Medicare allowable bad debts for the entire hospital comple	x (see instruc	tions)		260, 019	1
28. 00	Non-Medicare bad debt expense (line 26 minus line 27.01)	ovnono- /	notnuct! \		1, 744, 059	
29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt Cost of uncompensated care (line 23 column 3 plus line 29)	expense (see	INSTRUCTIONS)		695, 372 1, 048, 001	1
	Total unreimbursed and uncompensated care cost (line 19 plu	s line 30)			1, 048, 001	
200	The state of the s				., 5.5, 561	,

Cost Center Description   Salaries   Other   Total (col. + col. 2)   Ose   Col. 4   Col. 2   Ose   Cost Center Description   Salaries   Other   Total (col. + col. 2)   Ose   Ose   Col. 4   Ose   O
Cost Center Description
1.00   2.00   3.00   4.00   5.00   1.00   2.00   3.00   4.00   5.00   1.00   2.00   3.00   4.00   5.00   1.00   2.00   3.00   4.00   5.00   1.00   2.00   3.00   4.00   5.00   1.00   2.00   3.00   4.00   5.00   1.00
1.00   2.00   3.00   4.00   5.00
1.00   2.00   3.00   4.00   5.00
Company   Comp
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 144, 174 4, 264, 194 4, 408, 368 168, 320 4, 576, 688 4. 00 00500 ADMINISTRATIVE & GENERAL 2, 146, 773 5, 598, 356 7, 745, 129 -593, 317 7, 151, 812 5. 00 00700 OPERATION OF PLANT 270, 678 2, 265, 861 2, 536, 539 -906, 105 1, 630, 434 7. 00 0 916, 991 916, 991 916, 991 916, 991 916, 991 916, 991 916, 991 910, 390 616, 639 23, 239 639, 878 9. 00 00900 HOUSEKEEPING 516, 249 100, 390 616, 639 23, 239 639, 878 9. 00 00900 HOUSEKEEPING 531, 412 354, 911 886, 323 -501, 870 384, 453 10. 00 1100 CAFETERIA 0 0 0 524, 812 524, 812 11. 00 113. 00 01300 NURSING ADMINISTRATION 697, 039 2, 835 699, 874 14, 624 714, 498 13. 00 14. 00 01400 CENTRAL SERVICES & SUPPLY 71, 358 1, 024, 013 1, 095, 371 -288, 267 807, 104 14. 00 01600 MEDICAL RECORDS & LIBRARY 674, 272 160, 572 834, 844 74, 380 909, 224 10. 00 01600 MEDICAL RECORDS & LIBRARY 674, 272 160, 572 834, 844 74, 380 909, 224 10. 00 03000 ADULTS & PEDIATRICS 1, 140, 506 240, 180 1, 380, 686 -323, 816 1, 056, 870 30. 00 03000 ADULTS & PEDIATRICS 1, 140, 506 240, 180 1, 380, 686 -323, 816 1, 056, 870 30. 00 03100 INTENSIVE CARE UNIT 597, 102 92, 750 689, 852 15, 136 704, 988 31. 00 40. 00 04000 SUBPROVIDER - IPF 808, 476 729, 227 1, 537, 703 3, 120 1, 540, 823 40. 00
5. 00
7. 00   00700   OPERATI ON OF PLANT   270, 678   2, 265, 861   2, 536, 539   -906, 105   1, 630, 434   7. 00   7. 01   00701   OPERATI ON OF PLANT   0   0   0   0   916, 991   916, 991   7. 01   00701   OPERATI ON OF PLANT   0   0   0   0   916, 991   916, 991   7. 01   00701   OPERATI ON OF PLANT   0   0   124, 496   0   124, 496   0   124, 496   0   124, 496   8. 00   00900   OPERATI ON OF PLANT   0   0   124, 496   0   124, 496   0   124, 496   0   124, 496   8. 00   00900   OPERATI ON OF PLANT   0   0   0   0   0   0   0   0   0
7. 01 00701 OPERATION OF PLANT 0 0 0 124, 496 124, 496 0 124, 496 0 124, 496 9. 00 00900 HOUSEKEEPING 516, 249 100, 390 616, 639 23, 239 639, 878 9. 00 00900 HOUSEKEEPING 531, 412 354, 911 886, 323 -501, 870 384, 453 10. 00 1100 CAFETERIA 0 0 0 0 524, 812 524, 812 11. 00 01300 NURSI NG ADMINI STRATI ON 697, 039 2, 835 699, 874 14, 624 714, 498 13. 00 1400 CENTRAL SERVI CES & SUPPLY 71, 358 1, 024, 013 1, 095, 371 -288, 267 807, 104 14. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5, 914 5, 097, 098 15. 00 01500 PHARMACY 312, 276 4, 778, 908 5, 091, 184 5
9. 00   00900   HOUSEKEEPING   516, 249   100, 390   616, 639   23, 239   639, 878   9. 00   10. 00   01000   DI ETARY   531, 412   354, 911   886, 323   -501, 870   384, 453   10. 00   11. 00   01100   CAFETERIA   0   0   0   524, 812   524, 812   11. 00   13. 00   01300   NURSI NG ADMI NI STRATI ON   697, 039   2, 835   699, 874   14, 624   714, 498   13. 00   14. 00   01400   CENTRAL SERVI CES & SUPPLY   71, 358   1, 024, 013   1, 095, 371   -288, 267   807, 104   14. 00   15. 00   01500   PHARMACY   312, 276   4, 778, 908   5, 091, 184   5, 914   5, 097, 098   15. 00   01500   MEDI CAL RECORDS & LI BRARY   674, 272   160, 572   834, 844   74, 380   909, 224   16. 00   1000   MEDI CAL RECORDS & LI BRARY   674, 272   160, 572   834, 844   74, 380   909, 224   16. 00   1000
10. 00   01000   DI ETARY   531, 412   354, 911   886, 323   -501, 870   384, 453   10. 00   11. 00   01100   CAFETERI A   0   0   0   0   524, 812   524, 812   11. 00   13. 00   01300   NURSI NG ADMI NI STRATI ON   697, 039   2, 835   699, 874   14, 624   714, 498   13. 00   14. 00   01400   CENTRAL SERVI CES & SUPPLY   71, 358   1, 024, 013   1, 095, 371   -288, 267   807, 104   14. 00   15. 00   01500   PHARMACY   312, 276   4, 778, 908   5, 091, 184   5, 914   5, 097, 098   15. 00   01600   MEDI CAL RECORDS & LI BRARY   674, 272   160, 572   834, 844   74, 380   909, 224   16. 00   1000   NURSI NG ADMI NI STRATI ON   14. 00   1000   NURSI NG ADMI NI STRATI ON   14. 00   14. 00   15. 00   1000   NURSI NG ADMI NI STRATI ON   14. 00   14. 00   15. 00   1000   NURSI NG ADMI NI STRATI ON   14. 00   14. 00   15.
11. 00   01100   CAFETERIA   0   0   0   524, 812   524, 812   11. 00   13. 00   01300   NURSI NG ADMI NI STRATI ON   697, 039   2, 835   699, 874   14, 624   714, 498   13. 00   14. 00   01400   CENTRAL SERVI CES & SUPPLY   71, 358   1, 024, 013   1, 095, 371   -288, 267   807, 104   14. 00   15. 00   01500   PHARMACY   312, 276   4, 778, 908   5, 091, 184   5, 914   5, 097, 098   15. 00   01600   MEDI CAL RECORDS & LI BRARY   674, 272   160, 572   834, 844   74, 380   909, 224   16. 00   1000   NURSI NE SERVI CE COST CENTERS   1, 140, 506   240, 180   1, 380, 686   -323, 816   1, 056, 870   30. 00   31. 00   03100   INTENSI VE CARE UNI T   597, 102   92, 750   689, 852   15, 136   704, 988   31. 00   40. 00   04000   SUBPROVI DER - I PF   808, 476   729, 227   1, 537, 703   3, 120   1, 540, 823   40. 00   04000   SUBPROVI DER - I PF   808, 476   729, 227   1, 537, 703   3, 120   1, 540, 823   40. 00   10   10   10   10   10   10   10
13. 00   01300   NURSI NG ADMI NI STRATI ON   697, 039   2, 835   699, 874   14, 624   714, 498   13. 00   14. 00   01400   CENTRAL SERVI CES & SUPPLY   71, 358   1, 024, 013   1, 095, 371   -288, 267   807, 104   14. 00   15. 00   01500   PHARMACY   312, 276   4, 778, 908   5, 091, 184   5, 914   5, 097, 098   15. 00   01600   MEDI CAL RECORDS & LI BRARY   674, 272   160, 572   834, 844   74, 380   909, 224   16. 00   10.
15. 00   01500   PHARMACY   312, 276   4, 778, 908   5, 091, 184   5, 914   5, 097, 098   15. 00   16. 00   01600   MEDI CAL RECORDS & LI BRARY   674, 272   160, 572   834, 844   74, 380   909, 224   16. 00   18. 00   1
16. 00 01600 MEDI CAL RECORDS & LI BRARY 674, 272 160, 572 834, 844 74, 380 909, 224 16. 00 1 NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS 1, 140, 506 240, 180 1, 380, 686 -323, 816 1, 056, 870 30. 00 31. 00 03100 I NTENSI VE CARE UNI T 597, 102 92, 750 689, 852 15, 136 704, 988 31. 00 04000 SUBPROVI DER - I PF 808, 476 729, 227 1, 537, 703 3, 120 1, 540, 823 40. 00
INPATI ENT ROUTI NE SERVI CE COST CENTERS   30.00   03000   ADULTS & PEDI ATRI CS   1,140,506   240,180   1,380,686   -323,816   1,056,870   30.00   31.00   03100   INTENSI VE CARE UNI T   597,102   92,750   689,852   15,136   704,988   31.00   40.00   04000   SUBPROVI DER - I PF   808,476   729,227   1,537,703   3,120   1,540,823   40.00
30. 00   03000   ADULTS & PEDI ATRI CS   1, 140, 506   240, 180   1, 380, 686   -323, 816   1, 056, 870   30. 00   31. 00   03100   I NTENSI VE CARE UNI T   597, 102   92, 750   689, 852   15, 136   704, 988   31. 00   40. 00   04000   SUBPROVI DER - I PF   808, 476   729, 227   1, 537, 703   3, 120   1, 540, 823   40. 00   4
40. 00   04000   SUBPROVI DER - I PF   808, 476   729, 227   1, 537, 703   3, 120   1, 540, 823   40. 00
41.00   04100  30BPROVIDER - 1RF   0  0, 230  0, 230  0  0, 230  41.00
42. 00   04200   SUBPROVI DER   0 0 0 0 0 42. 00
43. 00   04300   NURSERY 0 0 0 345, 585 345, 585 43. 00
ANCILLARY SERVICE COST CENTERS
50. 00   05000   0PERATING ROOM   618, 231   1, 261, 248   1, 879, 479   12, 101   1, 891, 580   50. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   938, 158   1, 592, 328   2, 530, 486   36, 042   2, 566, 528   54. 00   60. 00   06000   LABORATORY   651, 890   1, 209, 235   1, 861, 125   27, 863   1, 888, 988   60. 00
65. 00   06500   RESPI RATORY THERAPY   366, 554   50, 873   417, 427   6, 575   424, 002   65. 00
66. 00 06600 PHYSI CAL THERAPY 473, 853 14, 911 488, 764 9, 519 498, 283 66. 00
69. 00   06900  ELECTROCARDI OLOGY   0   0   69. 00
69. 01   06901   CARDI AC REHAB   184, 162   13, 787   197, 949   3, 487   201, 436   69. 0°   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0 0 0 0 71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 291, 929 291, 929 72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00
OUTPATIENT SERVICE COST CENTERS
91. 00   09100   EMERGENCY   1, 171, 587   809, 834   1, 981, 421   22, 517   2, 003, 938   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00
93. 00   04050   CLI NI C
93. 01   04950   BI C   0   21, 016   21, 016   185   21, 201   93. 0
93. 05   04954   PODI ATRY   0   0   0   93. 05
OTHER REI MBURSABLE COST CENTERS  95. 00 09500   AMBULANCE SERVI CES 0 0 0 0 95. 00
101. 00 10100 HOME HEALTH AGENCY 24, 151 14, 932 39, 083 274 39, 357 101. 00
SPECIAL PURPOSE COST CENTERS
116. 00 11600 HOSPI CE 0 4, 847 4, 847 164 5, 011 116. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 16, 712, 023 28, 589, 524 45, 301, 547 -21, 649 45, 279, 898 118. 00 NONREI MBURSABLE COST CENTERS
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00
191. 00   19100   RESEARCH   0   0   0   0   191. 00
191. 01 19101 FMH DI AGNOSTI C CENTER 89, 621 6, 941 96, 562 3, 412 99, 974 191. 0
191. 02 19102 WELLNESS
192. 00  19200  PHYSI CI ANS' PRI VATE OFFI CES   10, 927  6, 230  17, 157  1, 883  19, 040   192. 00  192. 01  19201  RFE   0   1, 998  0   1, 998  192. 00
192. 02 19202 MARKETI NG 65, 010 140, 848 205, 858 -29, 393 176, 465 192. 02
192. 03 19203 FOUNDATION   0  0  0  0  0 192. 03
192. 06 19206   HEART CENTER 0 0 0 0 0 192. 06 192. 07 19207   WVCP 1, 744, 765 655, 141 2, 399, 906 38, 657 2, 438, 563 192. 07
192. 07   19207   WVCP   1, 744, 765   655, 141   2, 399, 906   38, 657   2, 438, 563   192. 07   192. 08   19208   OCCUPATI ONAL MED   0   3, 190   0   3, 190   0   3, 190   0   3, 190   0   0   0   0   0   0   0   0   0
192. 10 19210 HOSPI TALI ST 280, 676 883, 343 1, 164, 019 5, 500 1, 169, 519 192. 10
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 1, 644 1, 644 0 1, 644 194. 0
200.00   TOTAL (SUM OF LINES 118 through 199)   18,986,095   30,390,731   49,376,826   0   49,376,826   200.00

Provider CCN: 15-0064

				2/26/2018 10	): 28 am
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation	1	
	OFNEDAL CERVILOE COCT OFNITERO	6. 00	7. 00		
1 00	GENERAL SERVICE COST CENTERS	22 442	2 220 547	,	1 00
1.00	00100 CAP REL COSTS-BLDG & FLXT	-22, 443			1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	., ,		4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	-1, 248, 228			5. 00
7.00	00700 OPERATION OF PLANT	-382			7. 00
7. 01	00701 OPERATION OF PLANT	0			7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	0			8. 00
9. 00	00900 HOUSEKEEPI NG	0	639, 878		9. 00
10.00	01000 DI ETARY	0	384, 453		10.00
11. 00	01100 CAFETERI A	-214, 365		l e e e e e e e e e e e e e e e e e e e	11. 00
	01300 NURSING ADMINISTRATION	-55			13. 00
	01400 CENTRAL SERVICES & SUPPLY	0			14. 00
	01500 PHARMACY	-2, 728, 879			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-9, 248	899, 976	o	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	_		ı	
30.00	03000 ADULTS & PEDI ATRI CS	0			30. 00
31. 00	03100 I NTENSI VE CARE UNI T	0	704, 988		31. 00
	04000 SUBPROVI DER - I PF	0	,		40. 00
41. 00	04100 SUBPROVI DER - I RF	0			41. 00
	04200 SUBPROVI DER	0			42. 00
43. 00	04300 NURSERY	0	345, 585	j	43. 00
	ANCILLARY SERVICE COST CENTERS	T	T	T	
50. 00	05000 OPERATING ROOM	-870, 107			50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-189, 592			54. 00
60. 00	06000 LABORATORY	0	,		60. 00
65. 00	06500 RESPI RATORY THERAPY	0	424, 002		65. 00
66. 00	06600 PHYSI CAL THERAPY	-27, 770		l e e e e e e e e e e e e e e e e e e e	66. 00
	06900 ELECTROCARDI OLOGY	0	0		69. 00
	06901 CARDI AC REHAB	0		l e e e e e e e e e e e e e e e e e e e	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		l e e e e e e e e e e e e e e e e e e e	72. 00
/3.00	07300 DRUGS CHARGED TO PATIENTS	0	0	)	73. 00
04.00	OUTPATIENT SERVICE COST CENTERS	F00 000	1 440 (00	N.	
	09100 EMERGENCY	-590, 239	1, 413, 699	<b>'</b>	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4 000 504	4 0/4 045		92.00
	04050 CLINIC	-4, 092, 586		l control of the cont	93. 00
	04950 BI C	-6, 942			93. 01
93. 05	04954 PODI ATRY	0	0	)	93. 05
	OTHER REIMBURSABLE COST CENTERS			, I	
	09500 AMBULANCE SERVICES	-3, 443			95. 00
101.00	10100 HOME HEALTH AGENCY	0	39, 357		101. 00
11/ 00	SPECIAL PURPOSE COST CENTERS		F 011	T	11/ 00
	11600 HOSPI CE	10,004,070			116. 00
118.00	3 /	-10, 004, 279	35, 275, 619	/	118. 00
100.00	NONREI MBURSABLE COST CENTERS				100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		i de la companya del companya de la companya de la companya del companya de la co	190. 00 191. 00
	19100 RESEARCH	0	l .		
	19101 FMH DIAGNOSTIC CENTER	0	1	l control of the cont	191. 01
	19102 WELLNESS	0			191. 02
	19200 PHYSICIANS' PRIVATE OFFICES	0			192. 00
	19201   RFE	0	, , , , , ,		192. 01
	19202 MARKETI NG	0			192. 02
	19203 FOUNDATION	0			192. 03
	19206 HEART CENTER	0			192. 06
	19207 WVCP	0			192. 07
	19208 OCCUPATI ONAL MED	0			192. 08
	19210 HOSPI TALI ST	0			192. 10
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	1, 644	l e e e e e e e e e e e e e e e e e e e	194. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	-10, 004, 279	39, 372, 547	<b>'</b>	200. 00

Provider CCN: 15-0064 

					10	09/30/201/	2/26/2018 10	
		Increases			<u> </u>		12, 20, 2010 10	
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3.00	4. 00	5. 00				
Α -	- CAFETERI A							
. 00 CAI	FETERI A	1100	314, 661	<u>210, 1</u> 51				1.
0			314, 661	210, 151				
В -	- NURSERY							
. 00 NUI	RSERY	43.00	27 <u>1, 3</u> 12	7 <u>4, 2</u> 73				1.
0			271, 312	74, 273				
	- COACH RECLASS							
	PLOYEE BENEFITS DEPARTMENT	4. 00	168, 320	0				1
	MINISTRATIVE & GENERAL	5. 00	212, 287	0				2
00 OPI	ERATION OF PLANT	7. 00	10, 886	0				3.
00 HOI	USEKEEPI NG	9. 00	23, 239	0				4
00 DII	ETARY	10.00	22, 942	0				5.
00 NUI	RSING ADMINISTRATION	13.00	14, 624	0				6.
	NTRAL SERVICES & SUPPLY	14.00	3, 662	0				7
00 PH	ARMACY	15. 00	5, 914	0				8
00 MEI	DICAL RECORDS & LIBRARY	16. 00	74, 380	0				9.
. 00 ADI	ULTS & PEDIATRICS	30.00	21, 769	0				10
. 00 I N	TENSIVE CARE UNIT	31.00	15, 136	0				11
. 00 SUI	BPROVIDER - IPF	40.00	3, 120	0				12
. 00 OPI	ERATING ROOM	50.00	12, 101	0				13
. 00 RAI	DI OLOGY-DI AGNOSTI C	54.00	36, 042	0				14
. 00 LAI	BORATORY	60.00	27, 863	0				15
. 00 RES	SPI RATORY THERAPY	65.00	6, 575	0				16
. 00 PH	YSICAL THERAPY	66.00	9, 519	О				17
. 00 CAI	RDI AC REHAB	69. 01	3, 487	0				18
. 00 EMI	ERGENCY	91.00	22, 517	0				19
. 00 CLI	INIC	93.00	88, 949	О				20
.00 BI	c	93. 01	185	0				21
	ME HEALTH AGENCY	101.00	438	0				22
. 00 FM	H DIAGNOSTIC CENTER	191. 01	3, 412	0				23
	LLNESS	191. 02	1, 590	O				24
. 00 PH	YSICIANS' PRIVATE OFFICES	192.00	1, 883	O				25
	RKETING	192. 02	1, 278	0				26
. 00 WV	1	192. 07	38, 657	O				27
	SPI TALI ST	192. 10	5, 500					28
0		+	836, 275	0				
D .	- MARKETI NG			-1				
OO ADI	MINISTRATIVE & GENERAL	5. 00	9, 686	20, 985				1
0			9, 686	20, 985				
E ·	- HOSPI CE							1
OC HOS	SPI CE	116.00	164	0				1
0	+	+	164	<u>0</u>				
F.	- HOSPITAL UTILITIES							1
00 OPI	ERATION OF PLANT	7. 01	0	916, 991				1
0				916, 991				1
G ·	- IMPLANTABLE DEVICES							
	PL. DEV. CHARGED TO	72.00	0	291, 929				1
	TIENTS							
0	+	+		291, 929				1
0 00 Gr	and Total: Increases		1, 432, 098	1, 514, 329				500

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 10/01/2016 To 09/30/2017 Date/Time Prepared: 2/26/2018 10:28 am Provider CCN: 15-0064

					 2/26/2018 10: 28 8
	Decreases				
Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
6. 00	7. 00	8. 00	9. 00	10. 00	
A - CAFETERIA	40.00	24.4.4	040.454		
00 <u>DI ETARY</u>	1000	314, 661	21 <u>0, 1</u> 51		1
O NUIDCEDY		314, 661	210, 151		
B - NURSERY	20.00	271 212	74 070		
DO ADULTS & PEDIATRICS	30.00	27 <u>1, 3</u> 12	7 <u>4, 2</u> 73		1
U COACH DECLACE		271, 312	74, 273	3	
C - COACH RECLASS  ADMINISTRATIVE & GENERAL	5.00	836, 275	(	0	1
OO ADMINISTRATIVE & GENERAL	0.00	836, 275	(		2
00	0.00	ol Ol	(		3
00	0.00	Ol			3 4
00	0.00	ol Ol	(		5
00	0.00	ol Ol	(		6
00	0.00	ol Ol	(		
00	0.00	0	(		7 8
00	0.00	ol Ol	(		9
00	0.00	ol Ol			10
00	0.00	ol Ol			11
00	0.00	0	(		12
00	0.00	0	(		12
00	0.00	ol Ol	(		14
00	0.00	0	(		15
00 00	0. 00 0. 00	0	(		16
00	0.00	0	(		18
00	0.00	ol Ol	(		19
00	0.00	0			20
00	0.00	o			21
00	0.00	0	(		22
00	0.00	0	(		23
00	0.00	0			24
00	0.00	o o	(		25
00	0.00	o	(		26
00	0.00	0	(		27
00	0.00	0			28
		836, 275	<del>,</del>		20
D - MARKETING		000, 2, 0		-	
OO MARKETING	192. 02	9, 686	20, 985	5 0	1
0		9, 686	20, 985		
E - HOSPICE	<u> </u>	.,		-	
HOME HEALTH AGENCY	101.00	164	(	0	1
0		164	(		
F - HOSPITAL UTILITIES		.51			
OPERATION OF PLANT	7. 00	0	916, 991	1 0	1
0	— — <del>"</del> "†	<del> </del> _	916, 99		'
G - IMPLANTABLE DEVICES		3	, , , , ,		
CENTRAL SERVICES & SUPPLY	14. 00	0	291, 929	9 0	1
0	— — <del></del>	<del> </del>	291, 929		
D. 00 Grand Total: Decreases		1, 432, 098	1, 514, 329		500

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0064

					To 09/30/2017		pared:
				Acqui si ti ons		2/20/2010 10.	20 8111
		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, 094, 402	0		0	90, 677	1. 00
2.00	Land Improvements	520, 578	14, 779		0 14, 779		2. 00
3.00	Buildings and Fixtures	50, 749, 199	1, 278, 291		0 1, 278, 291	707, 006	3. 00
4.00	Building Improvements	0	0		0	0	4. 00
5.00	Fi xed Equipment	24, 531, 616	657, 280		0 657, 280		5. 00
6.00	Movable Equipment	35, 713	1, 108, 266		0 1, 108, 266	0	6. 00
7. 00	HIT designated Assets	0	0		0	0	7. 00
8. 00	Subtotal (sum of lines 1-7)	76, 931, 508	3, 058, 616		0 3, 058, 616	3, 068, 700	8. 00
9.00	Reconciling Items	0	0		0	0	9. 00
10.00	Total (line 8 minus line 9)	76, 931, 508	3, 058, 616		0 3, 058, 616	3, 068, 700	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	1, 003, 725	0				1. 00
2.00	Land Improvements	471, 366	0				2. 00
3.00	Buildings and Fixtures	51, 320, 484	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equipment	22, 981, 870	0				5. 00
6.00	Movable Equipment	1, 143, 979	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	76, 921, 424	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	76, 921, 424	0				10. 00

Heal th	Financial Systems F.	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Peri od:	Worksheet A-7	
					From 10/01/2016 Fo 09/30/2017		nared·
			SUMMARY OF CAPITAL				
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	44, 886	0	2, 217, 124	1 0	0	1.00
3.00	Total (sum of lines 1-2)	44, 886	0	2, 217, 124	1 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cast Canton Description	Other	Total (1) (sum				
	Cost Center Description		` ' `				
		Capi tal -Rel ate					
		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 & FLXT	0	2, 262, 010				1.00
3.00	Total (sum of lines 1-2)	o	2, 262, 010				3. 00

Health Financial Systems	AYETTE REGIONAL	. HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
				From 10/01/2016 To 09/30/2017	Part III   Date/Time Prep	arod:
				10 09/30/2017	2/26/2018 10: 2	
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col . 1 - col			
	1.00		2)			
DART III DECONOLILIATION OF CARLTAL COCTO	1.00	2.00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS (			F1 220 40	1 000000	0	1 00
1.00 CAP REL COSTS-BLDG & FIXT	51, 320, 484					1.00
3.00 Total (sum of lines 1-2)	51, 320, 484		0.1,0=01.0			3. 00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
·		Capi tal -Relate	cols. 5	·		
		d Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS (	ENTERS					
1.00 CAP REL COSTS-BLDG & FLXT	0	0		34, 965	0	1. 00
3.00 Total (sum of lines 1-2)	0			34, 965	0	3. 00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
cost center bescription	Tillerest	,	,	Capi tal -Rel ate		
		I IIS LI UC LI UIIS)	I listi ucti olis)	d Costs (see	through 14)	
				instructions)	tili ougii 14)	
	11. 00	12.00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS (			1			
1. 00 CAP REL COSTS-BLDG & FLXT	2, 204, 602	0		0 0	2, 239, 567	1. 00
3.00 Total (sum of lines 1-2)	2, 204, 602			0	2, 239, 567	3. 00
	•	•	•	,		

Peri od: Worksheet A-8 From 10/01/2016 To 09/30/2017 Date/Time Prepared: Provider CCN: 15-0064

				T.	o 09/30/2017			
				Expense Classification on		2/20/2016 10.2	20 4111	
				To/From Which the Amount is	to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.		
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00 0	1. 00	
2.00	COSTS-BLDG & FIXT (chapter 2)				2.00		2.00	
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2. 00	0	2. 00	
3.00	Investment income - other (chapter 2)		0		0.00	0	3. 00	
4.00	Trade, quantity, and time		0		0. 00	О	4. 00	
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00	
	expenses (chapter 8)		-					
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00	
7. 00	Tel ephone servi ces (pay		0		0. 00	О	7. 00	
	stations excluded) (chapter 21)							
8.00	Television and radio service (chapter 21)		0		0. 00	0	8. 00	
9.00	Parking Lot (chapter 21)		0		0. 00	0	9. 00	
10. 00	Provider-based physician adjustment	A-8-2	-5, 159, 227			0	10. 00	
11. 00	Sale of scrap, waste, etc.		0		0. 00	О	11. 00	
12. 00	(chapter 23) Related organization	A-8-1	0			o	12. 00	
13. 00	transactions (chapter 10) Laundry and Linen service		0		0.00	0	13. 00	
14. 00	Cafeteria-employees and guests		0		0.00		14. 00	
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00	
16. 00	Sale of medical and surgical		0		0.00	0	16. 00	
	supplies to other than patients							
17. 00	Sale of drugs to other than		0		0. 00	O	17. 00	
18. 00	patients Sale of medical records and	А	-9, 248	MEDICAL RECORDS & LIBRARY	16. 00	О	18. 00	
19. 00	abstracts Nursing and allied health		0		0.00	0	19. 00	
17.00	education (tuition, fees,		O		0.00	Ğ	17.00	
20. 00	books, etc.) Vending machines		0		0. 00	o	20. 00	
21. 00	Income from imposition of		0		0. 00	0	21. 00	
	interest, finance or penalty charges (chapter 21)							
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00	
	repay Medicare overpayments							
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00	
24.00	limitation (chapter 14)	4.0.2		DUVCI CAL THEDADY	// 00		24.00	
24.00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00	
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00	
25. 00	physicians' compensation		O	Cost center bereted	114.00		25. 00	
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00	
	COSTS-BLDG & FLXT							
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2. 00	0	27. 00	
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	•	28. 00 29. 00	
30.00	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	67. 00	•	30. 00	
	therapy costs in excess of limitation (chapter 14)							
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99	
31. 00	instructions) Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00	
	pathology costs in excess of limitation (chapter 14)							
32. 00	CAH HIT Adjustment for		0		0. 00	О	32. 00	
33. 00	Depreciation and Interest INTEREST OFFSET	В	-12. 522	CAP REL COSTS-BLDG & FIXT	1. 00	11	33. 00	
	1	- 1	. 2, 322	,		''!		

From 10/01/2016
To 09/30/2017 Date/Time Prepared:

					0 09/30/201/	2/26/2018 10:	
				Expense Classification on	Worksheet A	2, 20, 2010 101	
				To/From Which the Amount is			
					,		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3. 00	4. 00	5. 00	
33. 02	PFS BILLING SVC -OTHER REV	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	VENDOR REBATE/REFUND-OTHER REV	/ B	-107, 528	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33.04	PURCHASE DISC EARNED-OTHER REV	/ B	15, 138	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05	COLLEDTION FEES REV-OTHER REV	В	-3, 072	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
33.06	CAFETERIA SALES-OTHER REV	В	-213, 183	CAFETERI A	11. 00	0	33. 06
33. 07	CAF VEND MACHIN-OTHER REV	В	-1, 182	CAFETERI A	11. 00	0	33. 07
33. 08	EDUCATION & TRAINING-OTHER REV	/ B	-55	NURSING ADMINISTRATION	13. 00	0	33. 08
33.09	EMPLOYEE DRUG SALES-OTHER REV	В	-9, 442	PHARMACY	15. 00	0	33. 09
33. 10	PHY TH SCHOOL REV-OTHER REV	В	-27, 770	PHYSI CAL THERAPY	66.00	0	33. 10
33. 11	HELPLINE -OTHER REV	В	-3, 443	AMBULANCE SERVICES	95.00	0	33. 11
33. 12	THA DUES	Α	-1, 031	ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
33. 13	TELEVI SI ON	Α	-2, 641	ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
33. 14	TELEVISION ELECTRICITY	Α	-382	OPERATION OF PLANT	7. 00	0	33. 14
33. 15	24TH ST DEPRECIATION	A	-9, 921	CAP REL COSTS-BLDG & FIXT	1.00	9	33. 15
33. 16	PHYSICIAN RECRUITMENT	Α	-78, 259	ADMINISTRATIVE & GENERAL	5. 00	0	33. 16
33. 17	340B REVENUE	Α	-2, 719, 437	PHARMACY	15. 00	0	33. 17
33. 18	ER PURCHASED SERVICES	Α	-590, 239	EMERGENCY	91.00	0	33. 18
33. 19	HAF OFFSET	A	-1, 070, 700	ADMINISTRATIVE & GENERAL	5. 00	0	33. 19
50.00	TOTAL (sum of lines 1 thru 49)		-10, 004, 279				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

<sup>(1)</sup> 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.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0064

Peri od: Worksheet A-8-2 From 10/01/2016 To 09/30/2017 Date/Time Prepared:

2/26/2018 10:28 am Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov Identi fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3. 00 4.00 5. 00 6. 00 7. 00 93. 00 CLI NI C 1.00 3, 145, 403 291, 926 1. 00 179,000 3, 437, 329 1,632 2.00 93. 01 BI C 6, 942 6, 942 0 2.00 3.00 50. 00 OPERATING ROOM 870, 107 870, 107 0 3.00 0 54. 00 RADI OLOGY-DI AGNOSTI C 4.00 189, 592 189, 592 0 0 4.00 93. 00 CLI NI C 5.00 795, 703 795, 703 0 0 5.00 6.00 0.00 6.00 0 0 7.00 0.00 0 0 0 7.00 0 8.00 0.00 0 0 0 8.00 0 9.00 0.00 0 0 9.00 10.00 0.00 0 10.00 5, 299, 673 5,007,747 291, 926 1, 632 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Limit Unadjusted RCE Memberships & Component 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 93. 00 CLI NI C 7, 022 1. 00 1.00 140, 446 0 0 2.00 93. 01 BI C 0 0 0 2.00 3.00 50. 00 OPERATING ROOM 0 0 3.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 4.00 0 0 0 0 0 0 0 0 4.00 0 5.00 93. 00 CLI NI C 0 0 5 00 6.00 0.00 0 6.00 7.00 0.00 0 0 0 7.00 0 0.00 0 8.00 0 8.00 0.00 0 0 9.00 9.00 10.00 0.00 10.00 200.00 140, 446 7,022 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 1. 00 2.00 15. 00 16. 00 17. 00 18. 00 93. 00 CLI NI C 1. 00 1.00 140, 446 3, 296, 883 0 151, 480 2.00 93. 01 BI C 0 6, 942 2.00 3.00 50. 00 OPERATING ROOM 0 0 870, 107 3.00 0 4.00 54. 00 RADI OLOGY-DI AGNOSTI C 189, 592 4.00 0 93. 00 CLI NI C 5.00 0 795, 703 5 00 6.00 0.00 0 6.00 7.00 0.00 0 0 0 0 7.00 0.00 0 0 0 8.00 8.00 0.00 0 0 9.00 0 0 9.00 10.00 0.00 0 10.00 200.00 140, 446 151, 480 5, 159, 227 200.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 10/01/2016 Part I Provider CCN: 15-0064

				Fi	rom 10/01/2016 o 09/30/2017		
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
		0	1. 00	4. 00	4A	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	2, 239, 567		4 505 507			1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	4, 576, 688			( 424 001	4 424 001	4.00
5. 00 7. 00	00700 OPERATION OF PLANT	5, 903, 584 1, 630, 052		376, 321 69, 142	6, 424, 001 2, 657, 621	6, 424, 001 518, 103	5. 00 7. 00
7. 00	00701 OPERATION OF PLANT	916, 991	750, 427	09, 142	916, 991	178, 767	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	124, 496	1		127, 242	24, 806	8. 00
9.00	00900 HOUSEKEEPI NG	639, 878			783, 660	152, 775	9. 00
10.00	01000 DI ETARY	384, 453	15, 789	58, 860	459, 102	89, 502	10. 00
11. 00	01100 CAFETERI A	310, 447	22, 914	77, 270	410, 631	80, 053	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	714, 443		174, 760	889, 203		13.00
14. 00 15. 00	01400   CENTRAL SERVI CES & SUPPLY   01500   PHARMACY	807, 104 2, 368, 219			840, 554 2, 460, 897	163, 866 479, 752	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	899, 976		183, 843	1, 105, 615	215, 540	
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	077, 770	21,770	103, 043	1, 100, 010	213, 340	10.00
30.00	03000 ADULTS & PEDIATRICS	1, 056, 870	127, 854	218, 789	1, 403, 513	273, 615	30. 00
31.00	03100 INTENSIVE CARE UNIT	704, 988	51, 964	150, 344	907, 296	176, 877	31. 00
40. 00	04000 SUBPROVI DER - I PF	1, 540, 823			1, 784, 279		40. 00
41. 00	04100 SUBPROVI DER - I RF	6, 250		0	6, 250	1, 218	41. 00
42. 00	04200 SUBPROVI DER	0	0	0	420, 204	0 05 443	42.00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	345, 585	26, 074	66, 625	438, 284	85, 443	43. 00
50.00	05000 OPERATING ROOM	1, 021, 473	138, 704	154, 787	1, 314, 964	256, 352	50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 376, 936		239, 229	2, 739, 589		54.00
60.00	06000 LABORATORY	1, 888, 988	39, 933	166, 924	2, 095, 845	408, 585	60. 00
65. 00	06500 RESPI RATORY THERAPY	424, 002			535, 685		65. 00
66. 00	06600 PHYSI CAL THERAPY	470, 513		118, 699	632, 619		66. 00
69. 00	06900 ELECTROCARDI OLOGY	201 424	1/ /70	44 000	2/4 104	0	69.00
69. 01 71. 00	O6901   CARDI AC REHAB   O7100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	201, 436	16, 678	46, 080	264, 194 0	51, 505 0	69. 01 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	291, 929		0	291, 929	1	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		0	0		73. 00
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	1, 413, 699	47, 596	293, 230	1, 754, 525	342, 045	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 0/1 0/5	144 200	1 005 704	2 201 007	(24.0/1	92.00
93. 00 93. 01	04050 CLI NI C 04950 BI C	1, 961, 045 14, 259		1, 095, 734 45	3, 201, 087 14, 304	624, 061 2, 789	93. 00 93. 01
93. 05	04954 PODI ATRY	14, 239			14, 304	2, 769	93. 05
70.00	OTHER REIMBURSABLE COST CENTERS						70.00
95.00	09500 AMBULANCE SERVICES	-3, 443	0		-3, 443	0	95. 00
101.00	10100 HOME HEALTH AGENCY	39, 357	0	5, 998	45, 355	8, 842	101. 00
11/ 00	SPECIAL PURPOSE COST CENTERS	F 011		40	F 0F1	005	11/ 00
118.00	11600 HOSPICE   SUBTOTALS (SUM OF LINES 1 through 117)	5, 011 35, 275, 619					116.00
110.00	NONREI MBURSABLE COST CENTERS	35, 275, 019	2,039,093	4,010,004	34, 500, 643	5, 475, 432	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH	0	0	0	0	0	191. 00
	19101 FMH DIAGNOSTIC CENTER	99, 974	0	22, 846	122, 820	23, 944	191. 01
	19102 WELLNESS	186, 535		,	207, 325		191. 02
	19200 PHYSICIANS' PRIVATE OFFICES	19, 040		3, 146	29, 110		192. 00
	19201  RFE  19202  MARKETI NG	1, 998		12 900	1, 998		192. 01 192. 02
	19203 FOUNDATION	176, 465	7, 299 7, 886		197, 663 7, 886		192. 02
	19206 HEART CENTER	0	5, 274		5, 274		192. 06
	19207 WVCP	2, 438, 563			2, 994, 430		
192. 08	19208 OCCUPATIONAL MED	3, 190			3, 190		192. 08
	19210 HOSPI TALI ST	1, 169, 519		70, 275	1, 239, 794		
	07950 OTHER NONREIMBURSABLE COST CENTERS	1, 644	54, 570	0	56, 214		
200. 00 201. 00			_		0		200. 00 201. 00
201.00		39, 372, 547	2, 239, 567	4, 585, 586	39, 372, 547		
202.00	1.517.E (56 111.05 110 till ough 201)	07,072,047	2,257,507	1, 303, 300	57, 572, 547	1 5, 727, 001	_02.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0064

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2016 | Part I | To 09/30/2017 | Date/Time Prepared: | 2/26/2018 10: 28 am

						2/26/2018 10:	28 am
	Cost Center Description	OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		7.00	7. 01	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					I	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					I	5. 00
7.00	00700 OPERATION OF PLANT	3, 175, 724				I	7. 00
7. 01	00701 OPERATION OF PLANT	0	1, 095, 758			I	7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	7, 397	3, 709			I	8. 00
9. 00	00900 HOUSEKEEPI NG	30, 446	15, 268		982, 149		9. 00
10.00	01000 DI ETARY	42, 528	21, 327	17, 585			
11.00	01100 CAFETERIA	61, 721	30, 951	0	19, 728	0	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	40, 479	20, 299		12, 939	0	
15.00	01500 PHARMACY	39, 169	19, 642		12, 520	0	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	58, 708	29, 440	0	18, 765	0	16. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	244 202	172 (00	41 202	110 077	224 707	20.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	344, 383 139, 968	172, 698 70, 190			234, 787	
40. 00	04000 SUBPROVI DER – I PF	118, 937	70, 190	15, 093	44, 739 38, 017	42, 618 70, 453	
41. 00	04100 SUBPROVIDER - TPF	110, 937	0		30,017	70, 453	
42. 00	04200 SUBPROVI DER	0	0	0	0	0	
43. 00	04300 NURSERY	70, 233	35, 220	0	22, 449	0	
43.00	ANCILLARY SERVICE COST CENTERS	10, 233	33, 220		22, 447		43.00
50. 00	05000 OPERATI NG ROOM	373, 609	187, 354	14, 789	119, 419	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	332, 452	166, 715		106, 264	Ö	
60.00	06000 LABORATORY	107, 563	53, 940		34, 381	Ö	
65. 00	06500 RESPIRATORY THERAPY	54, 023	27, 091	0	17, 268	ő	
66. 00	06600 PHYSI CAL THERAPY	116, 919		18, 808		Ō	
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	Ō	1
69. 01	06901 CARDI AC REHAB	44, 924	22, 528	1, 380	14, 359	0	
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
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	128, 202	64, 290	28, 925	40, 978	15, 444	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					I	92. 00
93. 00	04050 CLI NI C	388, 705	59, 477	103	124, 243	0	1
93. 01	04950 BI C	0	0	0	0	0	
93. 05	04954 PODI ATRY	0	0	0	0	0	93. 05
	OTHER REIMBURSABLE COST CENTERS	1		1			
95. 00	09500 AMBULANCE SERVI CES	0	0		· ·		
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
444 04	SPECIAL PURPOSE COST CENTERS						144 00
	11600 HOSPI CE	0	1 050 770	_	· ·		116.00
118. 00	9 /	2, 500, 366	1, 058, 770	159, 996	787, 111	363, 302	]118.00
100 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	_	0	٥		190. 00
	19100 RESEARCH	0	0	0	· ·		191. 00
	19100 RESEARCH   19101 FMH DIAGNOSTIC CENTER	0	0	0	-		191. 00
	2 19102 WELLNESS	136, 985		0			191. 01
	19200 PHYSICIANS' PRIVATE OFFICES	18, 650	9, 353				192. 00
	1 19201 RFE	10,030	7, 555	2,027	3, 701		192. 01
	19202 MARKETI NG	19, 660	9, 859	0	6, 284		192. 02
	19203 FOUNDATION	21, 241	10, 652		6, 790		192. 03
	19206 HEART CENTER	14, 206			4, 541		192. 06
	7 19207 WVCP	317, 628				280, 336	
	19208 OCCUPATI ONAL MED	0	0	0	0		192. 08
	19210 HOSPI TALI ST		o o	o o	ام		192. 10
	07950 OTHER NONREIMBURSABLE COST CENTERS	146, 988	Ö	0	27, 784		194. 00
200.00			1		, - 1	1	200.00
201.00		o	0	0	ol	0	201. 00
202.00		3, 175, 724	1, 095, 758	163, 154	982, 149	643, 638	202. 00
		. '	•		٠ '		•

Provider CCN: 15-0064

				То	09/30/2017	Date/Time Pre 2/26/2018 10:	pared:
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	20 aiii
	<u>'</u>		ADMI NI STRATI ON	SERVICES &		RECORDS &	
		11.00	12.00	SUPPLY	15.00	LI BRARY	
	GENERAL SERVICE COST CENTERS	11. 00	13.00	14. 00	15. 00	16. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT						7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10. 00 11. 00	01000   DI ETARY   01100   CAFETERI A	402 004					10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	603, 084 19, 539	1				13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	4, 685		1, 082, 822			14. 00
15. 00	01500 PHARMACY	11, 591	1	0	3, 069, 460		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	35, 926	1	0	0	1, 463, 994	1
	INPATIENT ROUTINE SERVICE COST CENTERS		'	<u>'</u>	'		1
30. 00	03000 ADULTS & PEDIATRICS	37, 620		0	0	63, 977	30. 00
31. 00	03100   I NTENSI VE CARE UNI T	26, 310	1	0	0	16, 458	1
40.00	04000 SUBPROVI DER - I PF	36, 740	1	0	0	66, 820	1
41. 00	04100   SUBPROVI DER	C		0	0	17	1
42. 00 43. 00	04300 NURSERY	9, 428	37, 380	0	0	0 6, 064	
43.00	ANCI LLARY SERVI CE COST CENTERS	7, 420	37,300	O .	<u> </u>	0,004	45.00
50.00	05000 OPERATI NG ROOM	26, 363	104, 441	0	0	92, 877	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	39, 581	156, 814	0	0	346, 659	54.00
60.00	06000 LABORATORY	36, 194	1	0	0	265, 047	60. 00
65. 00	06500 RESPI RATORY THERAPY	17, 821		0	0	51, 021	1
66. 00	06600 PHYSI CAL THERAPY	19, 765		0	0	29, 474	1
69. 00	06900 ELECTROCARDI OLOGY	0.10	1 -1	0	0	7 100	
69. 01 71. 00	06901   CARDI AC REHAB   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	9, 187	1	1, 082, 822	0	7, 198 35, 911	69. 01 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS		1	1, 082, 822	0	10, 022	1
	07300 DRUGS CHARGED TO PATIENTS		1	o	3, 069, 460	151, 929	1
	OUTPATIENT SERVICE COST CENTERS						1
91. 00	09100 EMERGENCY	47, 751	0	0	0	228, 176	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	404 000				04 740	92.00
93. 00	04050 CLI NI C	101, 829	1	0	0	91, 712	1
93. 01 93. 05	04950   BI C   04954   PODI ATRY		1	0	0	33 8	1
73.03	OTHER REIMBURSABLE COST CENTERS		η	O <sub>1</sub>	O <sub>I</sub>	0	73.03
95. 00	09500 AMBULANCE SERVICES		o	0	0	0	95. 00
	10100 HOME HEALTH AGENCY	2, 556	10, 130	0	0	300	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11600 H0SPI CE	0	1 -1	0	0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	482, 886	1, 082, 092	1, 082, 822	3, 069, 460	1, 463, 994	]118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		ol	0	0	0	190. 00
	19100 RESEARCH		ol ol	0	o o		191. 00
	19101 FMH DIAGNOSTIC CENTER		ol ol	0	0		191. 01
191. 02	19102 WELLNESS	( c	o	0	0	0	191. 02
	19200 PHYSICIANS' PRIVATE OFFICES	C	0	0	0		192. 00
	19201  RFE	(	0	0	0		192. 01
	19202 MARKETI NG	2, 053		0	0		192. 02
	19203 FOUNDATION	2, 292	1	0	0		192. 03
	19206  HEART   CENTER  19207  WVCP	112 204		0	0		192.06
	19207 WCP	113, 286		0	0		192. 07 192. 08
	19210 HOSPI TALI ST	2, 567		0	0		192. 06
	07950 OTHER NONREIMBURSABLE COST CENTERS	2,307		0	0		194. 00
200.00					Ĭ	· ·	200. 00
201.00	Negative Cost Centers	c	o o	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	603, 084	1, 082, 092	1, 082, 822	3, 069, 460	1, 463, 994	202. 00

Period: Worksheet B
From 10/01/2016 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0064

					To 09/30/2017	Date/Time Prepared:
	Cost Center Description	Subtotal	Intern &	Total		2/26/2018 10: 28 am
	·	R	esi dents Cost			
			& Post Stepdown			
			Adjustments			
	OFFICE AND ASSOCIATION	24. 00	25. 00	26. 00		
1. 00	GENERAL SERVICE COST CENTERS  OO100 CAP REL COSTS-BLDG & FLXT					1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
7.00	00700 OPERATION OF PLANT					7.00
7. 01 8. 00	OO701   OPERATION OF PLANT   OO800   LAUNDRY & LINEN SERVICE					7. 01 8. 00
9. 00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10. 00
11. 00	01100 CAFETERI A					11.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY					13. 00 14. 00
15. 00	01500 PHARMACY					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2 021 075	ما	2 021 07	-	20.00
30. 00 31. 00	03100   NTENSIVE CARE UNIT	2, 831, 075 1, 543, 787	0	2, 831, 07! 1, 543, 78		30. 00 31. 00
40. 00	04000 SUBPROVI DER - I PF	2, 608, 660	o	2, 608, 660		40.00
41.00	04100 SUBPROVI DER - I RF	7, 485	О	7, 48		41. 00
42. 00	04200 SUBPROVI DER	704 501	0		0	42.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	704, 501	0	704, 50	1	43. 00
50.00	05000 OPERATI NG ROOM	2, 490, 168	0	2, 490, 16	8	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 444, 078	0	4, 444, 078		54. 00
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	3, 144, 895 877, 947	0	3, 144, 89! 877, 94		60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 115, 221	o	1, 115, 22		66. 00
69. 00	06900 ELECTROCARDI OLOGY	О	О		O	69. 00
69. 01	06901 CARDI AC REHAB	451, 642	0	451, 643		69. 01
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 118, 733 358, 863	ol Ol	1, 118, 73; 358, 86;		71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 221, 389	Ö	3, 221, 38		73. 00
04.00	OUTPATIENT SERVICE COST CENTERS		aT.	0 (50 00	.1	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 650, 336	0	2, 650, 33	6	91. 00 92. 00
93. 00	04050 CLINIC	4, 591, 217	Ö	4, 591, 21	7	93. 00
93. 01	04950 BI C	17, 126	O	17, 12		93. 01
93. 05	04954 PODI ATRY	8	0		8	93. 05
95 00	OTHER REIMBURSABLE COST CENTERS  O9500 AMBULANCE SERVICES	-3, 443	0	-3, 44	3	95. 00
	10100 HOME HEALTH AGENCY	67, 183	Ö	67, 18:		101. 00
	SPECIAL PURPOSE COST CENTERS					
116. 00 118. 00	11600 HOSPICE   SUBTOTALS (SUM OF LINES 1 through 117)	6, 327 32, 247, 198	0	6, 32 <sup>3</sup> 32, 247, 198		116. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	32, 247, 170	<u> </u>	32, 247, 170	5	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190. 00
	19100 RESEARCH 19101 FMH DIAGNOSTIC CENTER	0 146, 764	0	146, 76	2	191. 00 191. 01
	19101 FMH DIAGNOSTIC CENTER	428, 513	0	428, 51		191. 02
	19200 PHYSICIANS' PRIVATE OFFICES	71, 378	ō	71, 37		192. 00
	19201 RFE	2, 388	0	2, 38		192. 01
	19202 MARKETI NG 19203 FOUNDATI ON	274, 053 50, 398	O	274, 05: 50, 39		192. 02 192. 03
	19206 HEART CENTER	32, 173		32, 17		192. 06
192. 07	19207 WVCP	4, 389, 866	ō	4, 389, 86	6	192. 07
	19208 OCCUPATI ONAL MED	3, 812	O	3, 81:		192. 08
	19210 HOSPITALIST 07950 OTHER NONREIMBURSABLE COST CENTERS	1, 484, 059 241, 945	0	1, 484, 059 241, 949		192. 10 194. 00
200.00		241, 943	o			200. 00
201.00	Negative Cost Centers	0	O		o o	201. 00
202.00	TOTAL (sum lines 118 through 201)	39, 372, 547	O	39, 372, 54	7	202. 00

| Peri od: | Worksheet B | From 10/01/2016 | Part II | To 09/30/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0064

					Т	0 09/30/2017	Date/Time Pre 2/26/2018 10:	
				CAPI TAL			2/20/2018 10.	20 aiii
				RELATED COSTS				
		Cost Center Description	Directly	BLDG & FIXT	Subtotal		ADMI NI STRATI VE	
			Assigned New Capital			BENEFITS DEPARTMENT	& GENERAL	
			Related Costs			DELAKTIMENT		
			0	1.00	2A	4. 00	5. 00	
4 00		AL SERVICE COST CENTERS		T	T		T	
1. 00 4. 00		CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT	0	8, 898	8, 898	8, 898		1. 00 4. 00
5.00		ADMINISTRATIVE & GENERAL	0	144, 096		731		5. 00
7. 00		OPERATION OF PLANT	Ö	958, 427		134		1
7. 01		OPERATION OF PLANT	0	0	0	0	4, 030	7. 01
8.00	1	LAUNDRY & LINEN SERVICE	0	2, 746		0		1
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	0	11, 303 15, 789		257 114		9. 00 10. 00
11. 00	1	CAFETERIA	0	22, 914		150		1
13. 00	1	NURSI NG ADMI NI STRATI ON	Ö	0	0	339		1
14.00	1	CENTRAL SERVICES & SUPPLY	0	15, 028	15, 028			14. 00
15. 00		PHARMACY	0	14, 542		152		
16. 00		MEDICAL RECORDS & LIBRARY IENT ROUTINE SERVICE COST CENTERS	0	21, 796	21, 796	357	4, 859	16. 00
30. 00		ADULTS & PEDIATRICS	0	127, 854	127, 854	425	6, 168	30.00
31.00		INTENSIVE CARE UNIT	0	51, 964		292		
40. 00	1	SUBPROVI DER - I PF	0	44, 156	44, 156	387		
41.00		SUBPROVIDER - IRF	0	0	1	0		41. 00
42. 00 43. 00		SUBPROVI DER NURSERY	0	0 26, 074		0 129		42. 00 43. 00
43.00		LARY SERVICE COST CENTERS		20,074	20,074	127	1, 720	1 43.00
50.00		OPERATING ROOM	0	138, 704	138, 704	301	5, 779	50.00
54.00		RADI OLOGY-DI AGNOSTI C	0	123, 424		465		
60.00	1	LABORATORY	0	39, 933		324		1
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	0	20, 056 43, 407		178 231		
69. 00		ELECTROCARDI OLOGY	o	0	1	0		69. 00
69. 01	06901	CARDI AC REHAB	0	16, 678	16, 678	90	1, 161	69. 01
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1	
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0		0	1, 283 0	
73.00		TIENT SERVICE COST CENTERS						73.00
91.00		EMERGENCY	0	47, 596	47, 596	570	7, 711	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)			0			92. 00
93.00		CLINIC	0	144, 308	_	2, 119		1
93. 01 93. 05	04950	PODI ATRY	0	0		0	63	
75. 05		REIMBURSABLE COST CENTERS						73.03
95.00		AMBULANCE SERVICES	0	0	0	0	0	95. 00
101.00		HOME HEALTH AGENCY	0	0	0	12	199	101. 00
116 00		AL PURPOSE COST CENTERS HOSPICE	0	0	0	0	22	116. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1				
		IMBURSABLE COST CENTERS		2,007,070	2,007,070	.,,,,	120, 111	1
	1	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
		RESEARCH	0	0	0	0		191. 00
		FMH DIAGNOSTIC CENTER WELLNESS	0	0	0	44		191. 01 191. 02
	1	PHYSICIANS' PRIVATE OFFICES	0	6, 924	6, 924	6		192. 00
192. 01			0	0	0	0		192. 01
		MARKETI NG	0	7, 299		27		192. 02
		FOUNDATION	0	7, 886		0		192. 03
192.06		HEART CENTER WVCP	0	5, 274 117, 921		0 851		192. 06 192. 07
	1	OCCUPATIONAL MED	Ö	0		0		192. 08
192. 10	19210	HOSPI TALI ST	0	0	-	137	5, 449	192. 10
	1	OTHER NONREIMBURSABLE COST CENTERS	0	54, 570	54, 570	0	247	194. 00
200.00	1	Cross Foot Adjustments			0	_	_	200. 00 201. 00
201.00 202.00		Negative Cost Centers TOTAL (sum lines 118 through 201)	0	0 2, 239, 567	1	8, 898		
202.00	1	,		2,207,007	2,207,007	3,370	111,327	,_02.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0064

Peri od: Worksheet B From 10/01/2016 Part II To 09/30/2017 Date/Time Prepared:

2/26/2018 10:28 am Cost Center Description OPERATION OF OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY **PLANT** PLANT LINEN SERVICE 9.00 10.00 7.00 7.01 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 970, 241 7 00 7 00 7.01 00701 OPERATION OF PLANT 4,030 7.01 00800 LAUNDRY & LINEN SERVICE 2, 260 5, 579 8.00 14 8.00 9.00 00900 HOUSEKEEPI NG 9, 302 56 24, 362 9.00 C 01000 DI ETARY 12, 993 31, 930 10.00 10.00 78 601 337 11.00 01100 CAFETERI A 18, 857 489 0 11.00 114 C 13 00 01300 NURSING ADMINISTRATION 0 C 0 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 75 14 00 12.367 0 321 14.00 0 15.00 01500 PHARMACY 11, 967 72 0 311 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 17,936 108 465 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 105, 215 635 1, 415 2.730 11,647 31.00 03100 INTENSIVE CARE UNIT 42, 763 258 516 1, 110 2, 114 31.00 04000 SUBPROVI DER - I PF 3, 495 40.00 40.00 36, 337 0 943 04100 SUBPROVI DER - I RF 0 41.00 0 41.00 0 0 0 04200 SUBPROVI DER 0 42.00 0 r 0 0 42.00 04300 NURSERY 43.00 43.00 21, 457 130 557 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 114.144 690 506 2.962 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 101, 570 613 750 2,636 0 54.00 60.00 06000 LABORATORY 32,863 198 0 853 0 60.00 06500 RESPIRATORY THERAPY 16, 505 100 428 65.00 0 0 65.00 06600 PHYSI CAL THERAPY 66.00 35, 721 216 643 927 Λ 66,00 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 0 06901 CARDI AC REHAB 69.01 13, 725 83 47 356 0 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 C 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 91 00 09100 EMERGENCY 39 168 236 989 1 016 766 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 93.00 04050 CLI NI C 118, 757 219 3,083 0 93.00 4 04950 BIC 93.01 0 0 93.01 C 04954 PODI ATRY 0 93.05 0 0 0 0 93.05 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 0 95.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 0 C 0 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 0 116. 00 0 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 763, 907 3, 895 5, 471 19, 524 18, 022 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190, 00 0 191. 00 19100 RESEARCH 0 0 0 0 0 191.00 191. 01 19101 FMH DIAGNOSTIC CENTER 0 0 191. 01 0 0 0 41, 851 0 0 191.02 191. 02 19102 WELLNESS C 1,086 192.00 19200 PHYSICIANS' PRIVATE OFFICES 5,698 34 90 148 0 192.00 192. 01 19201 RFE 0 192.01 0 192. 02 19202 MARKETI NG 6,006 0 0 192. 02 36 156 192. 03 19203 FOUNDATI ON 6.490 39 0 168 0 192 03 192.06 19206 HEART CENTER 4,340 0 113 0 192.06 26 192. 07 19207 WVCP 97, 041 0 18 2, 478 13, 908 192. 07 192. 08 19208 OCCUPATI ONAL MED 0 192. 08 0 0 0 0 192. 10 19210 HOSPI TALI ST C 0 0 0 192, 10 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 44, 908 0 689 0 194.00 C 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 970, 241 4,030 5, 579 24.362 31, 930 202. 00

Provider CCN: 15-0064

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2016 Part II
To 09/30/2017 Date/Time Prepared: 2/26/2018 10:28 am

				10	09/30/2017	2/26/2018 10:	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON		PHARMACY	MEDI CAL RECORDS &	20 am
		11. 00	13.00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
1. 00 4. 00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 4. 00
5. 00 7. 00 7. 01	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT						5. 00 7. 00 7. 01
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	01100   CAFETERI A   01300   NURSI NG   ADMI NI STRATI ON	44, 329	1				11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 436 344		31, 865			14.00
15. 00	01500 PHARMACY	852		01,000	38, 953		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	2, 641	0	0	0	48, 162	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	2, 765		0	0	2, 103	1
31. 00 40. 00	03100 INTENSIVE CARE UNIT	1, 934 2, 701	547 765	0	0	541 2, 196	1
41. 00	04100 SUBPROVI DER - I RF	2, 701		0	ő	2, 170	1
42.00	04200 SUBPROVI DER	0	o	0	o	0	1
43. 00	04300 NURSERY	693	196	0	0	199	43. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	1 020	F 40		ما	2.052	T FO OO
50. 00 54. 00	05000   OPERATI NG ROOM   05400   RADI OLOGY-DI AGNOSTI C	1, 938 2, 909		0	0	3, 053 11, 439	1
60. 00	06000 LABORATORY	2, 660		0	ő	8, 711	1
65. 00	06500 RESPIRATORY THERAPY	1, 310		0	ō	1, 677	1
66.00	06600 PHYSI CAL THERAPY	1, 453		0	0	969	1
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	
69. 01 71. 00	06901   CARDI AC REHAB   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	675 0	191	31, 865	0	237 1, 180	1
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS			31, 803	0	329	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1	0	38, 953	4, 993	1
	OUTPAȚIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	3, 510	0	0	0	7, 499	1
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 485	0	0	0	3, 014	92. 00 93. 00
93. 01	04950 BI C	0	l o	0	ő	3, 014	1
93. 05	04954 PODI ATRY	0	0	0	0	0	93. 05
	OTHER REIMBURSABLE COST CENTERS		1				
	09500 AMBULANCE SERVICES	0 188		0	0	0	95. 00 101. 00
101.00	10100 HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	100	] 33	U	<u> </u>	10	1101.00
116.00	11600 HOSPI CE	0	0	0	0	10	116. 00
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	35, 494	5, 683	31, 865	38, 953	48, 162	118. 00
400.00	NONREI MBURSABLE COST CENTERS		1 0		ما		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  19100 RESEARCH	0	1	0	0		190. 00 191. 00
	19101 FMH DIAGNOSTIC CENTER			0	o		191. 00
	19102 WELLNESS	Ō		0	ō		191. 02
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	o		192. 00
	19201 RFE	0		0	0		192. 01
	19202  MARKETI NG   19203  FOUNDATI ON	151 168	0	0	0		192. 02 192. 03
	19206 HEART CENTER	100	0	0	0		192. 03
	19207 WVCP	8, 327	l o	0	o		192. 07
192. 08	19208 OCCUPATIONAL MED	0	0	0	O	0	192. 08
	19210 HOSPI TALI ST	189		0	0		192. 10
194. 00 200. 00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00 200. 00
200.00		n	ا	0	n	0	200.00
202. 00		44, 329	5, 683	31, 865	38, 953		202. 00
	- '		•	,	'		

| Period: | Worksheet B | From 10/01/2016 | Part II | To 09/30/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0064

					To 09/30/2017	
	Cost Center Description	Subtotal	Intern &	Total		2/26/2018 10: 28 am
	·	R	esidents Cost			
			& Post Stepdown			
			Adjustments			
	OFFICE ALL OFFICE OF SOUTH OF	24. 00	25. 00	26. 00		
	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FLXT					1. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00 7. 01	OO7OO  OPERATION OF PLANT   OO7O1  OPERATION OF PLANT					7. 00 7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11. 00 13. 00	O1100   CAFETERIA   O1300   NURSI NG   ADMINI STRATI ON					11. 00
	01400 CENTRAL SERVICES & SUPPLY					14. 00
	01500 PHARMACY					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS					16. 00
30. 00	03000 ADULTS & PEDIATRICS	261, 740	0	261, 74	10	30.00
	03100 INTENSIVE CARE UNIT	106, 027	0			31. 00
40.00	04000 SUBPROVI DER - I PF	98, 822	0	98, 82		40.00
41. 00 42. 00	04100   SUBPROVI DER   -	28	0		28 O	41. 00 42. 00
	04300 NURSERY	51, 361	0			43. 00
	ANCILLARY SERVICE COST CENTERS					
50. 00 54. 00	05000   OPERATI NG ROOM   05400   RADI OLOGY-DI AGNOSTI C	268, 626	0			50. 00 54. 00
60.00	06000 LABORATORY	256, 669 95, 506	0	95, 50		60.00
65. 00	06500 RESPIRATORY THERAPY	42, 979	0	42, 97		65. 00
66.00	06600 PHYSI CAL THERAPY	86, 758	0	86, 75		66. 00
69. 00 69. 01	06900  ELECTROCARDI OLOGY   06901  CARDI AC REHAB	0 33, 243	0	33, 24	0	69. 00 69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 243	0	33, 04		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 612	0	1, 61	2	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	43, 946	0	43, 94	16	73. 00
91. 00	OUTPATIENT SERVICE COST CENTERS  O9100 EMERGENCY	109, 061	0	109, 06	51	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92. 00
	04050 CLI NI C	293, 063	0			93. 00
	04950  BI C   04954  PODI ATRY	64	0		0	93. 01 93. 05
70.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>			76. 66
	09500 AMBULANCE SERVICES	0	0		0	95. 00
101. 00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	462	0	46	52	101. 00
116. 00	11600 HOSPI CE	32	0	3	32	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 783, 044	0	1, 783, 04	14	118. 00
	NONREI MBURSABLE COST CENTERS		0			100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0		0	190. 00 191. 00
	19101 FMH DIAGNOSTIC CENTER	584	0	•		191. 01
	19102 WELLNESS	43, 888	0			191. 02
	19200  PHYSICIANS' PRIVATE OFFICES   19201  RFE	13, 028	0		28 9	192. 00 192. 01
	19201 RFE 19202 MARKETI NG	14, 544	0	14, 54		192. 02
	19203 FOUNDATION	14, 786	Ö	14, 78		192. 03
	19206 HEART CENTER	9, 776	0	.,		192. 06
	19207 WVCP 19208 OCCUPATIONAL MED	253, 705 14	0	253, 70	05   4	192. 07 192. 08
	19210 HOSPI TALI ST	5, 775	0	5, 77		192. 08
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	100, 414	o	100, 41		194. 00
200.00	1 1	0	0	•	0	200. 00
201. 00 202. 00	3	0 2, 239, 567	0		0	201. 00 202. 00
202.00		2,237,307	Ч	2, 237, 30	"1	1202.00

	n Financial Systems ALLOCATION - STATISTIC		AYETTE REGIONAL		CN: 15-0064 P	eriod: rom 10/01/2016 o 09/30/2017	Worksheet B-1 Date/Time Pre 2/26/2018 10:	epared:
	Cost Center Des	cription	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)		ADMINISTRATIVE & GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	
	GENERAL SERVICE COST	CENTERS	1.00	4. 00	5A	5. 00	7. 00	
1.00	00100 CAP REL COSTS-B		400, 430					1.00
4.00 5.00 7.00 7.01 8.00 9.00	00400 EMPLOYEE BENEFI 00500 ADMINISTRATIVE 00700 OPERATION OF PL 00701 OPERATION OF PL 00800 LAUNDRY & LINEN 00900 HOUSEKEEPING	& GENERAL ANT ANT	1, 591 25, 764 171, 365 0 491 2, 021	18, 673, 601 1, 532, 471 281, 564 0 539, 488	-6, 424, 001 0 0 0 0	2, 657, 621 916, 991 127, 242 783, 660	210, 803 0 491 2, 021	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 S 01400 CENTRAL SERVI CE 01500 PHARMACY	S & SUPPLY	2, 823 4, 097 0 2, 687 2, 600	239, 693 314, 661 711, 663 75, 020 318, 190	0 0	840, 554 2, 460, 897	2, 823 4, 097 0 2, 687 2, 600	11. 00 13. 00 14. 00 15. 00
16. 00	01600 MEDICAL RECORDS		3, 897	748, 652	<u>.</u>	1, 105, 615	3, 897	16.00
30. 00 31. 00 40. 00 41. 00 42. 00 43. 00	O3000 ADULTS & PEDI AT O3100 I NTENSI VE CARE O4000 SUBPROVI DER - I O4100 SUBPROVI DER - I O4200 SUBPROVI DER O4300 NURSERY	RI CS UNI T PF RF	22, 860 9, 291 7, 895 0 0 4, 662	890, 963 612, 238 811, 596 0 0 271, 312	B 0 0 0 0	907, 296 1, 784, 279 6, 250 0	22, 860 9, 291 7, 895 0 0 4, 662	31. 00 40. 00 41. 00 42. 00
F0 00	ANCILLARY SERVICE COS	T CENTERS	04.000	/ 00 000		4 044 074	0.4.000	F0 00
50. 00 54. 00 60. 00	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGN 06000 LABORATORY	OSTI C	24, 800 22, 068 7, 140	630, 332 974, 200 679, 753	0	2, 739, 589	24, 800 22, 068 7, 140	54.00
65. 00 66. 00 69. 00 69. 01	06500 RESPI RATORY THE 06600 PHYSI CAL THERAP 06900 ELECTROCARDI OLO 06901 CARDI AC REHAB	Υ	3, 586 7, 761 0 2, 982	373, 129 483, 372 0 187, 649	0 0	632, 619 0	3, 586 7, 761 0 2, 982	66. 00 69. 00
71. 00 72. 00 73. 00	07100 MEDICAL SUPPLIE 07200 IMPL. DEV. CHAR 07300 DRUGS CHARGED T	O PATIENTS	0 0 0	0 0 0	0	0 291, 929	0	71.00
91. 00 92. 00 93. 00	OUTPATIENT SERVICE CO 09100 EMERGENCY 09200 OBSERVATION BED 04050 CLINIC		8, 510 25, 802	1, 194, 104 4, 462, 071		,	8, 510 25, 802	92.00
93. 01 93. 05	04950 BI C 04954 PODI ATRY		0	185 0	0	14, 304	0	93. 01
	OTHER REIMBURSABLE CO 09500 AMBULANCE SERVI 10100 HOME HEALTH AGE SPECIAL PURPOSE COST	CES NCY	0 0	24, 425				95. 00 101. 00
116. 00 118. 00	11600 HOSPI CE SUBTOTALS (SUM	OF LINES 1 through 117)	0 364, 693	164 16, 356, 895		5, 051 28, 086, 285		116. 00 118. 00
190.00	NONREI MBURSABLE COST 19000 GIFT, FLOWER, C		l ol	0	0	0	0	190. 00
191. 00 191. 01	19100 RESEARCH 19101 FMH DIAGNOSTIC 219102 WELLNESS		0 0	93, 033 84, 663	0	0 122, 820	0	191. 00 191. 01 191. 02
192.01	D 19200 PHYSI CLANS' PRI 1 19201 RFE 2 19202 MARKETI NG	VATE OFFICES	1, 238 0 1, 205	12, 810 0 56, 602	0	1, 998	0	192. 00 192. 00 192. 00
192.03	3 19203 FOUNDATION 5 19206 HEART CENTER		1, 305 1, 410 943	36, 602 0	0	7, 886	1, 410	192. 02 192. 03 192. 06
192. 03 192. 08 192. 10	7 19207 WVCP 3 19208 OCCUPATIONAL ME 0 19210 HOSPITALIST		21, 084 0 0	1, 783, 422 0 286, 176	0	2, 994, 430 3, 190 1, 239, 794	21, 084 0 0	192. 0 192. 0 192. 1
200. 00 201. 00	Negative Cost C	stments enters	9, 757	0	0	56, 214		194. 00 200. 00 201. 00
202.00	Part I) Unit cost multi	cated (per Wkst. B, plier (Wkst. B, Part I)	2, 239, 567 5. 592905	4, 585, 586 0. 245565	5	6, 424, 001 0. 194950		203. 00
204.00	Part II)	cated (per Wkst. B, plier (Wkst. B, Part		8, 898 0. 000477		0. 004395	970, 241 4. 602596	

		AYETTE REGIONAL				u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provi der CO	CN: 15-0064   F	eriod: rom 10/01/2016	Worksheet B-1	
					o 09/30/2017	Date/Time Pre	pared:
						2/26/2018 10:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	(MAN HOURS)	
		(SQUARE TELT)	LAUNDRY)				
		7. 01	8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	OO5OO   ADMINISTRATIVE & GENERAL   OO7OO   OPERATION OF PLANT						5.00
7. 00 7. 01	00700 OPERATION OF PLANT	145, 045					7. 00 7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	491	1				8.00
9. 00	00900 HOUSEKEEPING	2, 021	1	203, 965			9. 00
10.00	01000 DI ETARY	2, 823	l e	2, 823	1		10.00
11. 00	01100 CAFETERI A	4, 097	0	4, 097	0	490, 557	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	_	0	0	15, 893	1
14. 00 15. 00	01400   CENTRAL SERVI CES & SUPPLY   01500   PHARMACY	2, 687	1	2, 687		3, 811	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 600 3, 897		2, 600 3, 897		9, 428 29, 223	
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	3,077		3, 077	<u> </u>	27, 223	10.00
30.00	03000 ADULTS & PEDI ATRI CS	22, 860	16, 046	22, 860	22, 758	30, 601	30.00
31.00	03100 INTENSIVE CARE UNIT	9, 291	5, 851	9, 291	4, 131	21, 401	31.00
40.00	04000 SUBPROVI DER - I PF	0	0	7, 895		29, 885	
41.00	04100 SUBPROVI DER – I RF	0	0	C	-	0	
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	1 442	0	1 440	i i	7 440	
43.00	ANCI LLARY SERVI CE COST CENTERS	4, 662	.[ 0	4, 662		7, 669	43.00
50.00	05000 OPERATING ROOM	24, 800	5, 733	24, 800	0	21, 444	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	22, 068			1	32, 196	1
60.00	06000 LABORATORY	7, 140	0	7, 140	0	29, 441	60.00
65. 00	06500 RESPI RATORY THERAPY	3, 586		3, 586		14, 496	1
66. 00	06600 PHYSI CAL THERAPY	7, 761	1	7, 761	1	16, 077	1
69. 00 69. 01	06900   ELECTROCARDI OLOGY   06901   CARDI AC REHAB	2, 982	1	2, 982	-	0 7, 473	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 702	0	2, 702	0	7,473	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		ő		Ö	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	8, 510	11, 213	8, 510	1, 497	38, 841	1
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 873	40	25, 802	0	82, 829	92.00
93. 00	04950 BI C	7,075	0	25, 602	1	02, 027	1
93. 05	04954 PODI ATRY	0	Ö	Ċ	1	0	1
	OTHER REIMBURSABLE COST CENTERS						]
	09500 AMBULANCE SERVICES	0				0	
101.00	10100 HOME HEALTH AGENCY	0	0	C	0	2,079	101. 00
116 00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE	1 0	0		O	0	116. 00
118.00		140, 149			1		
	NONREI MBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,	1997.19	227 = 13		1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	1		190. 00
	19100 RESEARCH	0	_	C			191. 00
	19101 FMH DIAGNOSTIC CENTER	0	0	0	0		191. 01
	19102 WELLNESS  19200 PHYSICIANS' PRIVATE OFFICES	1, 238	1, 019	9, 093 1, 238			191. 02 192. 00
	19201 RFE	1, 230	1,019	1, 230	1		192. 00
	19202 MARKETI NG	1, 305	Ö	1, 305	_		192. 02
	19203 FOUNDATI ON	1, 410		1, 410			192. 03
	19206 HEART CENTER	943		,			192. 06
	19207 WVCP	0	205	20, 745	27, 173		192. 07
	19208 OCCUPATI ONAL MED 19210 HOSPI TALI ST				0		192. 08 192. 10
	07950 OTHER NONREIMBURSABLE COST CENTERS			5, 770			194. 00
200.00	1			0, 770			200. 00
201.00							201. 00
202.00		1, 095, 758	163, 154	982, 149	643, 638	603, 084	202. 00
202 00	Part I)	7 554407	2 570504	4 015000	10 21//0/	1 220204	202 00
203.00 204.00		7. 554607 4, 030	1		1	1. 229386 44 329	203.00
204.00	Part II)	4,030	3,379	24, 302	. 31, 730	44, 329	204.00
205.00	1 /	0. 027784	0. 088208	0. 119442	0. 511797	0. 090365	205. 00
					[		

	<i>y</i>	-AYETTE REGIONAL				u of Form CMS-2552-1
COST ALLO	CATION - STATISTICAL BASIS		Provi der CC		eriod: rom 10/01/2016	Worksheet B-1
				To		Date/Time Prepared: 2/26/2018 10:28 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	2/20/2018 10: 28 alli
	·	ADMI NI STRATI ON	SERVICES &	(100%)	RECORDS &	
		(FTE' S)	SUPPLY (100%)		LI BRARY (GROSS	
		, ,			CHARGES)	
CEN	ERAL SERVICE COST CENTERS	13.00	14. 00	15. 00	16. 00	
	OO CAP REL COSTS-BLDG & FLXT					1. 00
4.00 004	OO EMPLOYEE BENEFITS DEPARTMENT					4. 00
	OO ADMINISTRATIVE & GENERAL					5. 00
•	OO OPERATION OF PLANT O1 OPERATION OF PLANT					7. 00 7. 0
	OO LAUNDRY & LINEN SERVICE					8. 00
	00 HOUSEKEEPI NG					9. 00
	OO CAFETERIA					10.00
	OO CAFETERIA OO NURSING ADMINISTRATION	10, 682				11. 00
	00 CENTRAL SERVICES & SUPPLY	0	100			14. 00
	OO PHARMACY	453	0	100		15. 00
	OO MEDI CAL RECORDS & LI BRARY	0	0	0	93, 067, 932	16. 00
	ATIENT ROUTINE SERVICE COST CENTERS OO ADULTS & PEDIATRICS	1, 471	0	0	4, 067, 183	30.00
	00 INTENSIVE CARE UNIT	1, 029	0	0	1, 046, 311	31. 00
	OO SUBPROVIDER - IPF	1, 437	0	0	4, 247, 965	40.00
	00 SUBPROVI DER - I RF	0	0	0	1, 087	41. 00
	OO  SUBPROVI DER OO  NURSERY	369	0	0 0	385, 517	42. 00 43. 00
	I LLARY SERVI CE COST CENTERS	1 007	<u> </u>	o <sub>l</sub>	555,517	10.00
4	OO OPERATING ROOM	1, 031	0	0	5, 904, 468	50.00
	OO RADI OLOGY-DI AGNOSTI C	1, 548	0	0	22, 035, 714	54. 00
4	00 LABORATORY 00 RESPIRATORY THERAPY	1, 415 697	0	0	16, 849, 765 3, 243, 536	60.00
4	00 PHYSI CAL THERAPY	773	0	Ö	1, 873, 713	66.00
	00 ELECTROCARDI OLOGY	O	0	0	0	69.00
	OT CARDI AC REHAB	359	0	0	457, 603	69. 0
1	00 MEDICAL SUPPLIES CHARGED TO PATIENTS 00 IMPL. DEV. CHARGED TO PATIENTS	0	100 0	0	2, 282, 933 637, 133	71. 00 72. 00
1	OO DRUGS CHARGED TO PATIENTS	Ö	0	100	9, 658, 580	73. 00
	PATIENT SERVICE COST CENTERS		_			
	00 EMERGENCY 00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	14, 505, 769	91. 00
	50 CLINIC	o	0	0	5, 830, 412	93. 00
93. 01 049	50 BI C	0	0	0	2, 108	93. 01
	54 PODI ATRY	0	0	0	536	93. 05
	ER REIMBURSABLE COST CENTERS OO AMBULANCE SERVICES	O	0	0	0	95. 00
	OO HOME HEALTH AGENCY	100	0		19, 071	101. 00
	CLAL PURPOSE COST CENTERS					
1	OO HOSPI CE	0	0	-	18, 528	116. 00
118. 00 NON	SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	10, 682	100	100	93, 067, 932	118. 00
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190. 00
	00 RESEARCH	0	0	0	0	191. 00
1	01 FMH DIAGNOSTIC CENTER	0	0	0	0	191. 01
	02 WELLNESS OO PHYSICIANS' PRIVATE OFFICES		0	0	0	191. 02 192. 00
192. 01 192		o	0	Ö	Ö	192. 01
	02 MARKETI NG	o	0	0	O	192. 02
	O3 FOUNDATION	0	0	0	0	192. 03
192. 06 192	06 HEART CENTER	0	0	0	0	192. 06 192. 07
	08 OCCUPATI ONAL MED	o	0	ő	o	192. 08
	10 H0SPI TALI ST	O	0	0	0	192. 10
	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194. 00
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers					200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 082, 092	1, 082, 822	3, 069, 460	1, 463, 994	202. 00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	1	10, 828. 220000		0. 015730	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	5, 683	31, 865	38, 953	48, 162	204. 00
		1		ll		
205.00	Unit cost multiplier (Wkst. B, Part	0. 532016	318. 650000	389. 530000	0. 000517	205. 00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0064	Peri od: From 10/01/2016	Worksheet C Part I

09/30/2017 Date/Time Prepared: To 2/26/2018 10:28 am Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 2.00 3.00 4. 00 5. 00 1.00 INPATIENT ROUTINE SERVICE COST CENTERS 2, 831, 075 30 00 03000 ADULTS & PEDIATRICS 30 00 2, 831, 075 2, 831, 075 31.00 03100 INTENSIVE CARE UNIT 1, 543, 787 1, 543, 787 0 1, 543, 787 31.00 0 04000 SUBPROVIDER - IPF 2, 608, 660 40.00 2, 608, 660 2, 608, 660 40.00 04100 SUBPROVI DER - I RF 7, 485 7, 485 7, 485 41.00 41.00 04200 SUBPROVI DER 0 42.00 0 Ω Ω 42.00 43.00 04300 NURSERY 704, 501 704, 501 0 704, 501 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 2, 490, 168 2, 490, 168 0 2, 490, 168 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 4, 444, 078 4, 444, 078 4, 444, 078 54.00 60.00 06000 LABORATORY 3, 144, 895 3, 144, 895 0 0 0 3, 144, 895 60.00 65.00 06500 RESPIRATORY THERAPY 877, 947 877, 947 877, 947 65.00 06600 PHYSI CAL THERAPY 66.00 1, 115, 221 1, 115, 221 1, 115, 221 66.00 69.00 06900 ELECTROCARDI OLOGY C 0 69.00 06901 CARDI AC REHAB 451, 642 451, 642 451, 642 69.01 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 118, 733 1, 118, 733 1, 118, 733 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 358, 863 358, 863 358, 863 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 221, 389 3, 221, 389 3, 221, 389 73.00 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 2, 650, 336 2, 650, 336 2, 650, 336 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 616, 706 616, 706 616, 706 92.00 04050 CLI NI C 93.00 4, 591, 217 4, 591, 217 151, 480 4, 742, 697 93.00 93 01 04950 BIC 17, 126 17, 126 17, 126 93.01 0 04954 PODI ATRY 93.05 8 8 0 8 93.05 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 95.00 101.00 10100 HOME HEALTH AGENCY 67, 183 67, 183 67, 183 101. 00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 6, 327 6, 327 6, 327 116. 00 32, 867, 347 32, 867, 347 200.00 Subtotal (see instructions) 0 151, 480 33, 018, 827 200. 00 201.00 616, 706 616, 706 201. 00 Less Observation Beds 616, 706 202.00 Total (see instructions) 32, 250, 641 0 32, 250, 641 151, 480 32, 402, 121 202. 00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0064	Peri od:	Worksheet C

From 10/01/2016 To 09/30/2017 Part I Date/Time Prepared: 2/26/2018 10:28 am Title XVIII Hospi tal PPS Charges TEFRA Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other I npati ent + col . 7) Ratio Ratio 9. 00 6.00 7.00 8.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 3, 397, 787 3, 397, 787 03000 ADULTS & PEDIATRICS 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 1,046,311 1, 046, 311 31.00 04000 SUBPROVIDER - IPF 4, 247, 965 4, 247, 965 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 1, 087 1, 087 41.00 04200 SUBPROVI DER 42.00 42.00 0 C 43.00 04300 NURSERY 385, 517 385, 517 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0.000000 50.00 859, 671 5.044.797 5, 904, 468 0.421743 50.00 22, 035, 714 05400 RADI OLOGY-DI AGNOSTI C 20, 930, 709 54.00 1, 105, 005 0.201676 0.000000 54 00 60.00 06000 LABORATORY 2, 264, 650 14, 585, 115 16, 849, 765 0.186643 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 805, 095 2, 438, 441 3, 243, 536 0. 270676 0.000000 65.00 245, 093 06600 PHYSI CAL THERAPY 1, 873, 713 1, 628, 620 0.595193 0.000000 66.00 66.00 0.000000 69.00 06900 ELECTROCARDI OLOGY 0 C 0.000000 69.00 06901 CARDI AC REHAB 457, 603 457, 603 0. 986973 0.000000 69.01 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 606, 828 1, 676, 105 2, 282, 933 0.490042 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.563247 0.000000 72 00 72 00 15.732 621, 401 637, 133 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 383, 348 7, 275, 232 9, 658, 580 0.333526 0.00000073.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 899, 503 13, 606, 266 14, 505, 769 0. 182709 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 669, 396 669, 396 0.921287 0.000000 92.00 93.00 04050 CLI NI C 429 5, 829, 983 5, 830, 412 0.787460 0.000000 93.00 04950 BI C 8. 124288 93. 01 0 2, 108 2, 108 0.000000 93.01 93 05 04954 PODI ATRY 0 536 536 0.014925 0.000000 93.05 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 0.000000 0.000000 95.00 101.00 10100 HOME HEALTH AGENCY 19, 071 19, 071 0 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 18, 528 18, 528 116.00 200.00 Subtotal (see instructions) 18, 264, 021 74, 803, 911 93, 067, 932 200. 00 201 00 Less Observation Beds 201 00 93, 067, 932 202.00 Total (see instructions) 18, 264, 021 74, 803, 911 202.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0064	From 10/01/2016	Worksheet C Part I Date/Time Prepared:

					2/26/2018 10:	28 am
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
40.00	04000 SUBPROVI DER - I PF					40. 00
41.00	04100 SUBPROVI DER - I RF					41. 00
42.00	04200 SUBPROVI DER					42. 00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 421743				50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 201676				54.00
60.00	06000 LABORATORY	0. 186643				60.00
65.00	06500 RESPIRATORY THERAPY	0. 270676				65.00
66.00	06600 PHYSI CAL THERAPY	0. 595193				66. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69. 00
69. 01	06901 CARDI AC REHAB	0. 986973				69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 490042				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 563247				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 333526				73. 00
	OUTPATIENT SERVICE COST CENTERS	•				
91.00	09100 EMERGENCY	0. 182709				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 921287				92. 00
93.00	04050 CLI NI C	0. 813441				93. 00
93. 01	04950 BI C	8. 124288				93. 01
93. 05	04954 PODI ATRY	0. 014925				93. 05
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>				
95.00	09500 AMBULANCE SERVI CES	0. 000000				95. 00
101.00	10100 HOME HEALTH AGENCY					101.00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>				
116.00	11600 H0SPI CE					116. 00
200.00						200.00
201.00						201.00
202.00	Total (see instructions)					202. 00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0064	Peri od:	Worksheet C

To 09/30/2017 Part I Date/Time Prepared: 2/26/2018 10:28 am Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs Di sal I owance from Wkst. B, Adj Part I, col. 26) 2.00 3.00 4. 00 5. 00 1.00 INPATIENT ROUTINE SERVICE COST CENTERS 2, 831, 075 30 00 03000 ADULTS & PEDIATRICS 30 00 2, 831, 075 2, 831, 075 31.00 03100 INTENSIVE CARE UNIT 1, 543, 787 1, 543, 787 0 1, 543, 787 31.00 0 04000 SUBPROVIDER - IPF 2, 608, 660 2, 608, 660 2, 608, 660 40.00 40.00 04100 SUBPROVI DER - I RF 7, 485 7, 485 7, 485 41.00 41.00 04200 SUBPROVI DER 0 42.00 0 Ω Ω 42.00 43.00 04300 NURSERY 704, 501 704, 501 0 704, 501 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 2, 490, 168 2, 490, 168 0 2, 490, 168 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 4, 444, 078 4, 444, 078 4, 444, 078 54.00 60.00 06000 LABORATORY 3, 144, 895 3, 144, 895 0 0 0 3, 144, 895 60.00 65.00 06500 RESPIRATORY THERAPY 877, 947 877, 947 877, 947 65.00 06600 PHYSI CAL THERAPY 66.00 1, 115, 221 1, 115, 221 1, 115, 221 66.00 69.00 06900 ELECTROCARDI OLOGY C 0 69.00 06901 CARDI AC REHAB 451, 642 451, 642 451, 642 69.01 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 118, 733 1, 118, 733 1, 118, 733 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 358, 863 358, 863 358, 863 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 221, 389 3, 221, 389 3, 221, 389 73.00 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 2, 650, 336 2, 650, 336 0 2, 650, 336 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 616, 706 616, 706 616, 706 92.00 04050 CLI NI C 93.00 4, 591, 217 4, 591, 217 151, 480 4, 742, 697 93.00 93 01 04950 BIC 17, 126 17, 126 17, 126 93.01 0 04954 PODI ATRY 93.05 8 8 0 8 93.05 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 95.00 101.00 10100 HOME HEALTH AGENCY 67, 183 67, 183 67, 183 101. 00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 6, 327 6, 327 6, 327 116. 00 32, 867, 347 32, 867, 347 200.00 Subtotal (see instructions) 0 151, 480 33, 018, 827 200. 00 201.00 616, 706 616, 706 201. 00 Less Observation Beds 616, 706 202.00 Total (see instructions) 32, 250, 641 0 32, 250, 641 151, 480 32, 402, 121 202. 00

From 10/01/2016 Part I 09/30/2017 Date/Time Prepared: 2/26/2018 10:28 am Title XIX Hospi tal Cost Charges TEFRA Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other I npati ent + col . 7) Ratio Ratio 9. 00 6.00 7.00 8.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 3, 397, 787 03000 ADULTS & PEDIATRICS 3, 397, 787 30.00 30.00 03100 INTENSIVE CARE UNIT 31.00 1,046,311 1, 046, 311 31.00 04000 SUBPROVIDER - IPF 4, 247, 965 4, 247, 965 40.00 40.00 04100 SUBPROVI DER - I RF 1, 087 41.00 1, 087 41.00 04200 SUBPROVI DER 42.00 42.00 0 C 43.00 04300 NURSERY 385, 517 385, 517 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0.000000 50.00 859, 671 5.044.797 5, 904, 468 0.421743 50.00 22, 035, 714 05400 RADI OLOGY-DI AGNOSTI C 20, 930, 709 54.00 1, 105, 005 0.201676 0.000000 54 00 60.00 06000 LABORATORY 2, 264, 650 14, 585, 115 16, 849, 765 0.186643 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 805, 095 2, 438, 441 3, 243, 536 0. 270676 0.000000 65.00 245, 093 06600 PHYSI CAL THERAPY 1,628,620 1, 873, 713 0.595193 0.000000 66.00 66.00 0.000000 69.00 06900 ELECTROCARDI OLOGY 0 C 0.000000 69.00 06901 CARDI AC REHAB 457, 603 457, 603 0. 986973 0.000000 69.01 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 606, 828 1, 676, 105 2, 282, 933 0.490042 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 637, 133 0.563247 0.000000 72 00 72 00 15.732 621, 401 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 383, 348 7, 275, 232 9, 658, 580 0.333526 0.00000073.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 899, 503 13, 606, 266 14, 505, 769 0. 182709 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 669, 396 669, 396 0.921287 0.000000 92.00 93.00 04050 CLI NI C 429 5, 829, 983 5, 830, 412 0.787460 0.000000 93.00 04950 BI C 8. 124288 93. 01 0 2, 108 2, 108 0.000000 93.01 93 05 04954 PODI ATRY 0 536 536 0.014925 0.000000 93.05 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 0.000000 0.000000 95.00 101.00 10100 HOME HEALTH AGENCY 19, 071 0 19,071 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 18, 528 18, 528 116.00 200.00 Subtotal (see instructions) 18, 264, 021 74, 803, 911 93, 067, 932 200. 00 201 00 Less Observation Beds 201 00

18, 264, 021

74, 803, 911

93, 067, 932

202.00

202.00

Total (see instructions)

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0064	Peri od: Worksheet C From 10/01/2016 Part I To 09/30/2017 Date/Ti me Prepared: 2/26/2018 10: 28 am

					2/26/2018 10:	28 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 INTENSIVE CARE UNIT					31. 00
40.00	04000 SUBPROVI DER - I PF					40. 00
41.00	04100 SUBPROVI DER - I RF					41. 00
42.00	04200 SUBPROVI DER					42. 00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60.00	06000 LABORATORY	0. 000000				60.00
65.00	06500 RESPIRATORY 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 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	OUTPATIENT SERVICE COST CENTERS					
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. 05	04954 PODI ATRY	0. 000000				93. 05
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVI CES	0. 000000				95. 00
101.00	10100 HOME HEALTH AGENCY					101.00
	SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPI CE					116. 00
200.00						200.00
201.00						201.00
202.00	Total (see instructions)					202. 00

Health Financial Systems	FAYETTE REGIONAL	. HEALTH SYSTEM	1	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAI	PITAL COSTS	Provi der C		Period: From 10/01/2016 Fo 09/30/2017		pared: 28 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 & PEDIATRICS	261, 740	0	261, 740	2, 254	116. 12	30. 00
31.00 INTENSIVE CARE UNIT	106, 027		106, 02		391. 24	31. 00
40. 00 SUBPROVIDER - IPF	98, 822	0	98, 82	2, 242	44. 08	40. 00
41. 00 SUBPROVI DER - I RF	28	0	2	3 0	0.00	41.00
42. 00 SUBPROVI DER	0	0		0	0.00	42.00
43. 00 NURSERY	51, 361		51, 36	1 324	158. 52	43.00
200.00 Total (lines 30 through 199)	517, 978		517, 978	5, 091		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	835	96, 960	)			30.00
31.00 INTENSIVE CARE UNIT	169	66, 120	)			31. 00
40. 00 SUBPROVI DER - I PF	1, 585	69, 867	'			40.00
41. 00 SUBPROVI DER - I RF	0	0				41. 00
42. 00 SUBPROVI DER	0	0				42. 00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	2, 589	232, 947	,			200. 00
	•	•	-			

	5					6.5. 040.4	
		AYETTE REGIONAL				eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Peri od: From 10/01/2016	Worksheet D	
					To 09/30/2017	Part II Date/Time Pre	nared:
					10 07/30/2017	2/26/2018 10:	
			Ti tl e	XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	t Inpatient	Capital Costs	
	·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000  OPERATI NG ROOM	268, 626	5, 904, 468	0. 04549	5 252, 442	11, 485	50.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	256, 669	22, 035, 714	0. 01164	8 898, 666	10, 468	54.00
60.00	06000 LABORATORY	95, 506	16, 849, 765	0. 00566	8 1, 071, 589	6, 074	60.00
65.00	06500 RESPI RATORY THERAPY	42, 979	3, 243, 536	0. 01325	1 571, 876	7, 578	65. 00
66.00	06600 PHYSI CAL THERAPY	86, 758	1, 873, 713	0. 04630	3 62, 298	2, 885	66. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	69. 00
69. 01	06901 CARDI AC REHAB	33, 243	457, 603	0. 07264	6 0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 045	2, 282, 933	0. 01447	5 269, 312	3, 898	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 612	637, 133	0. 00253	0 3, 345	8	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	43, 946	9, 658, 580	0. 00455	0 713, 235	3, 245	73. 00
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	109, 061	14, 505, 769	0. 00751	8 645, 798	4, 855	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	57, 016	669, 396	0. 08517	5 0	0	92.00
93.00	04050 CLI NI C	293, 063	5, 830, 412	0. 05026	5 339	17	93. 00
93. 01	04950 BI C	64	2, 108	0. 03036	1 0	0	93. 01
93. 05	04954 PODI ATRY	0	536	0. 00000	0 0	0	93. 05
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	1, 321, 588	83, 951, 666		4, 488, 900	50, 513	200. 00

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM	ı	In lie	eu of Form CMS-:	2552_10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER			CN: 15-0064	Period: From 10/01/2016 To 09/30/2017	Worksheet D	pared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Post-Stepdown Adjustments		Post-Stepdow Adjustments		All Other Medical Education Cost	
INDATIONE DOUTING CODY CONTERC	1A	1.00	2A	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	0	0	ı	0 0	0	30.00
31. 00   03100   NTENSI VE CARE UNI T	0		1	0 0	0	
40. 00   04000 SUBPROVI DER -   PF				0 0	0	
41. 00   04100   SUBPROVI DER -   I RF	0			0 0	0	
42. 00   04200   SUBPROVI DER	0	0		0 0	o o	
43. 00   04300   NURSERY	0	Ö	,	0 0	Ō	
200.00 Total (lines 30 through 199)	0	0	)	0 0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	4.00	minus col. 4) 5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	2, 25	0.00	835	30.00
31. 00 03100 I NTENSI VE CARE UNI T		0			169	
40. 00   04000   SUBPROVI DER - 1 PF	0	0	2, 24		1, 585	40.00
41. 00   04100   SUBPROVI DER -   RF	0	0		0.00	0	41.00
42. 00   04200   SUBPROVI DER	0	0	)	0.00	0	42.00
43. 00   04300   NURSERY		0			•	
200.00 Total (lines 30 through 199)		0	5, 09	)1	2, 589	200. 00
Cost Center Description	I npati ent					
	Program Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
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   SUBPROVI DER -   PF	0					40. 00
41. 00   04100   SUBPROVI DER -	0					41. 00
42. 00   04200   SUBPROVI DER						42.00
43.00   04300   NURSERY 200.00   Total (lines 30 through 199)	0					43. 00 200. 00
200.00    Total (Titles 30 tillough 199)	ı	I				1200.00

Heal th	Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM	1	In Lie	u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	RVICE OTHER PASS	S Provider C		Period: From 10/01/2016 To 09/30/2017		
			Titl∈	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician				Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000   OPERATI NG ROOM	0	C		0 0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
60.00	06000 LABORATORY	0	C		o o	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	C		ol ol	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	C		ol ol	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	C		ol ol	0	69. 00
69. 01	06901 CARDI AC REHAB	0	C		ol ol	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ċ		ol ol	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ċ		ol ol	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Ċ		ol ol	0	73. 00
	OUTPATIENT SERVICE COST CENTERS	,		'	-1		
91.00	09100 EMERGENCY	0	C		0 0	0	91. 00
02 00	00200 OBSEDVATION BEDS (NON DISTINCT DART)		۰ ا			0	02.00

0

0

0

0

0

91. 00 92. 00 93. 00

93. 0595. 00

0 200. 00

0

0

0 93. 01

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

93. 05 04954 PODI ATRY
OTHER REI MBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVI CES

93. 00 | 04050 | CLI NI C

04950 BI C

93.01

200.00

					6.5	
	AYETTE REGIONAL				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider Co		Period: From 10/01/2016	Worksheet D Part IV	
THROUGH COSTS				Γο 09/30/2017		pared:
					2/26/2018 10:	28 am
			XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of col 1		(from Wkst. C,		
	Education Cost	,	Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and	8)	7)	
	4.00	F 00	4)	7.00	0.00	
ANOLLI ADV. CEDVI CE COCT CENTEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCI LLARY SERVICE COST CENTERS  50. 00 05000 OPERATING ROOM		0	<u> </u>	E 004 440	0.000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	)	5, 904, 468 22, 035, 714		
60. 00 06000 LABORATORY	0	0	)	16, 849, 765		
65. 00 06500 RESPI RATORY THERAPY	0	0	)	3, 243, 536		
66. 00   06600 PHYSI CAL THERAPY	0	0	)	1, 873, 713		
69. 00   06900   ELECTROCARDI OLOGY	0	0	)	1,0/3,/13	0.000000	
69. 01   06901   CARDI AC   REHAB	0	0	)	457, 603		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	)	2, 282, 933		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	637, 133		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	)	9, 658, 580		
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	<u> </u>	7, 030, 300	0.000000	73.00
91. 00 09100 EMERGENCY	0	0		14, 505, 769	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	Ö	0	ì	669, 396		
93. 00   04050   CLINI C	0	0	ĺ	5, 830, 412		1
93. 01   04950   BI C	0	0	ĺ	2, 108		
93. 05   04954   PODI ATRY	0	0		536		
OTHER REIMBURSABLE COST CENTERS	-			-1	0.00000	1
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	o	0		83, 951, 666		200. 00
		•	•	•		•

Heal th	Financial Systems FA	AYETTE REGIONAL	HEALTH SYSTEM		In Li€	eu of Form CMS-:	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	RVICE OTHER PASS			Period: From 10/01/2016 To 09/30/2017	Date/Time Pre 2/26/2018 10:	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0. 000000	252, 442		0 1, 804, 092		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	898, 666		0 7, 591, 020		54. 00
60.00	06000 LABORATORY	0. 000000	1, 071, 589		0 2, 809, 754	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	571, 876		0 1, 226, 607	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	62, 298		0 14, 779	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
69. 01	06901 CARDI AC REHAB	0. 000000	0		0 265, 182	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	269, 312		0 487, 888	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 345		0 218, 081	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	713, 235		0 2, 952, 752	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0. 000000	645, 798		0 3, 217, 316	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 638, 795	0	92.00
93.00	04050 CLI NI C	0.000000	339		0 1, 591, 993	0	93. 00
93. 01	04950 BI C	0. 000000	0		0	0	93. 01
93.05	04954 PODI ATRY	0. 000000	0		0	0	93. 05
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)		4, 488, 900		0 22, 818, 259	0	200. 00

Health Financial Systems	FAYETTE REGIONAL HE	EALTH SYSTEM	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0064	Peri od: From 10/01/2016	Worksheet D Part V

09/30/2017 Date/Time Prepared: To 2/26/2018 10:28 am Title XVIII Hospi tal Costs Charges Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1.00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 421743 1, 804, 092 760, 863 50.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 201676 7, 591, 020 0 1, 530, 927 54.00 06000 LABORATORY 2, 809, 754 0 524, 421 60 00 0 186643 60 00 06500 RESPIRATORY THERAPY 0 0 65.00 0. 270676 1, 226, 607 332, 013 65.00 66.00 06600 PHYSI CAL THERAPY 0. 595193 14, 779 0 0 8, 796 66.00 0 0 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 Ω 06901 CARDI AC REHAB 0 0 69.01 0.986973 265, 182 261, 727 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.490042 487, 888 0 0 239, 086 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0.563247 218, 081 0 122, 833 72.00 07300 DRUGS CHARGED TO PATIENTS 2, 952<u>,</u> 752 28, 540 0. 333526 0 984, 820 73.00 73 00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0. 182709 3, 217, 316 0 0 587, 833 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0. 921287 638, 795 0 588, 514 92.00 0 0 04050 CLI NI C 1, 591, 993 93.00 0.787460 1, 253, 631 93.00 93.01 04950 BI C 8. 124288 0 0 0 93.01 04954 PODI ATRY 0. 014925 0 93.05 93.05 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0.000000 95.00 0 0 200.00 Subtotal (see instructions) 22, 818, 259 28, 540 7, 195, 464 200.00 Less PBP Clinic Lab. Services-Program 201.00 0 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 22, 818, 259 0 28, 540 7, 195, 464 202. 00

Health Financial Systems	FAYETTE REGIONAL HE	ALTH SYSTEM	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0064	Peri od: From 10/01/2016 To 09/30/2017	Worksheet D Part V Date/Time Prepared: 2/26/2018 10:28 am
		Title XVIII	Hospi tal	DDS

				10 09/30/2017	2/26/2018 10:28 am	
		Title	XVIII	Hospi tal	PPS	_
<u> </u>	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCI LLARY SERVI CE COST CENTERS		_	1			_
50. 00   05000   OPERATI NG ROOM	0	0			50. 00	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0			54. 00	
60. 00   06000   LABORATORY	0	0			60. 00	
65. 00 06500 RESPI RATORY THERAPY	0	0			65. 00	
66. 00   06600   PHYSI CAL THERAPY	0	0			66. 00	
69. 00 06900 ELECTROCARDI OLOGY	0	0			69. 00	
69. 01   06901   CARDI AC   REHAB	0	0			69. 0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71. 00	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0			72. 00	
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	9, 519			73. 00	0
OUTPATIENT SERVICE COST CENTERS			1			
91. 00 09100 EMERGENCY	0	0			91. 00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92. 00	
93. 00   04050   CLI NI C	0	0			93. 00	
93. 01   04950 BI C		0			93. 0	
93. 05   04954   PODI ATRY OTHER REI MBURSABLE COST CENTERS		0			93. 0	5
95. 00 09500 AMBULANCE SERVICES		I	I		95. 00	Ω.
200.00 Subtotal (see instructions)		9, 519			200. 00	
201.00 Less PBP Clinic Lab. Services-Program		9, 519			201. 00	
Only Charges					201.00	U
202.00 Net Charges (line 200 - line 201)		9, 519			202. 00	ın
202.00	1	1 7, 517	I		1202.00	J

Heal th	Financial Systems FA	AYETTE REGIONAL	. HEALTH SYSTEM		In Lie	eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der CO	CN: 15-0064	Peri od:	Worksheet D	
					From 10/01/2016		
			Component (	CCN: 15-S064	To 09/30/2017		
			Ti +Lo	: XVIII	Subprovi der -	2/26/2018 10: PPS	28 alli
					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)					
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	268, 626					50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	256, 669				1, 759	
60.00	06000 LABORATORY	95, 506					
65.00	06500 RESPI RATORY THERAPY	42, 979					65. 00
66. 00	06600 PHYSI CAL THERAPY	86, 758	1, 873, 713			5, 548	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	69. 00
69. 01	06901 CARDI AC REHAB	33, 243	457, 603	0. 07264		0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 045	2, 282, 933	0. 01447	<sup>7</sup> 5 4, 977	72	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 612	637, 133	0. 00253	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	43, 946	9, 658, 580	0. 00455	50 491, 745	2, 237	73.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	109, 061	14, 505, 769	0. 00751	8 106, 481	801	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	669, 396	0.00000	00	0	92.00
93.00	04050 CLI NI C	293, 063	5, 830, 412	0. 05026	55 0	0	93. 00
93. 01	04950 BI C	64	2, 108	0. 03036	0	0	93. 01
93. 05	04954 PODI ATRY	0	536	0.00000	00	0	93. 05
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	1, 264, 572	83, 951, 666		1, 166, 577	12, 123	200. 00

	<u> </u>	AYETTE REGIONAL				eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der C	CN: 15-0064	Peri od:	Worksheet D	
THROUG	SH COSTS		Component	CCN, 1E CO//	From 10/01/2016		nanad.
			Component	CCN: 15-S064	To 09/30/2017	Date/Time Pre 2/26/2018 10:	pareu: 28 am
			Title	: XVIII	Subprovi der -	PPS	20 4111
					I PF		
	Cost Center Description	Non Physician	Nursing School	Nursing Scho	ol Allied Health	Allied Health	
	·		Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50. 00
54.00	05400   RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
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 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
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. 05	04954 PODI ATRY	0	0		0 0	0	93. 05
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0		0 0	0	200. 00

Heal th	Financial Systems F.	AYETTE REGIONAL	. HEALTH SYSTEM		In Li∈	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUG	H COSTS		Component		From 10/01/2016 To 09/30/2017	Part IV Date/Time Pre 2/26/2018 10:	pared: 28 am
			Title	: XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of col 1		(from Wkst. C,		
		Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col. 2, 3 and 4)	8)	7)	
		4.00	5. 00	6, 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
50.00	05000 OPERATI NG ROOM	0	0		0 5, 904, 468	0.000000	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 22, 035, 714	0. 000000	54.00
60.00	06000 LABORATORY	0	0		0 16, 849, 765		60.00
65.00	06500 RESPIRATORY THERAPY	0	0		0 3, 243, 536		65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 1, 873, 713		
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0.000000	69.00
69. 01	06901 CARDI AC REHAB	0	0		0 457, 603	0. 000000	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 2, 282, 933	0. 000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 637, 133		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 9, 658, 580	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS	1					
91.00	09100 EMERGENCY	0	0		0 14, 505, 769	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 669, 396	0.000000	92.00
93.00	04050 CLI NI C	0	0		0 5, 830, 412	0.000000	93.00
93. 01	04950 BI C	0	0		0 2, 108	0.000000	93. 01
93.05	04954 PODI ATRY	0	0		0 536	0.000000	93. 05
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0		0 83, 951, 666		200. 00

Heal th	Financial Systems FA	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider CO	CN: 15-0064	Peri od:	Worksheet D	
	H COSTS				From 10/01/2016		
			Component (	CCN: 15-S064	To 09/30/2017	Date/Time Pre 2/26/2018 10:	
			Title	XVIII	Subprovi der -	PPS	20 alli_
				XVIII	IPF	113	
	Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS				_		
50.00	05000  OPERATI NG ROOM	0. 000000	48		0	0	50.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0. 000000	151, 001		0	0	54.00
60.00	06000 LABORATORY	0. 000000	286, 393		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	6, 111		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0.000000	119, 821		0 0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69. 00
69. 01	06901 CARDI AC REHAB	0. 000000	0		0 0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	4, 977		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	491, 745		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS	'	·				
91.00	09100 EMERGENCY	0.000000	106, 481		0 0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92. 00
93.00	04050 CLI NI C	0. 000000	0		0 0	0	93.00
93. 01	04950 BI C	0. 000000	0		0 0	0	93. 01
93. 05	04954 PODI ATRY	0. 000000	0		0 0	0	93. 05
	OTHER REIMBURSABLE COST CENTERS	,					
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)		1, 166, 577		0 0	0	200. 00

Heal th	Financial Systems FA	AYETTE REGIONAL	. HEALTH SYSTEM		In Lie	eu of Form CMS-:	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co	CN: 15-0064	Peri od:	Worksheet D	
				00N 45 TO 4	From 10/01/2016		
			Component	CCN: 15-T064	To 09/30/2017	Date/Time Pre 2/26/2018 10:	pared: 28 am
			Title	: XVIII	Subprovi der -	PPS	20 aiii
					I RF		
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		9	(column 3 x	
		(from Wkst. B,			l. Charges	column 4)	
		Part II, col.	8)	2)			
		26)			4 00		
	ANOLLI ADV. CEDVI OF LOCK OFFITEDS	1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	2/0/2/	F 004 4/0	0.0454	٥٦	1 0	F0 00
	05000 OPERATING ROOM	268, 626				0	
	05400 RADI OLOGY-DI AGNOSTI C	256, 669		l .		0	0 00
	06000 LABORATORY	95, 506		1		0	
	06500 RESPI RATORY THERAPY	42, 979				0	
66. 00	06600 PHYSI CAL THERAPY	86, 758				0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0		0.0000		0	69. 00
	06901 CARDI AC REHAB	33, 243		1		0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 045				0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 612		l .		0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	43, 946	9, 658, 580	0. 0045	50 0	0	73. 00
04 00	OUTPATIENT SERVICE COST CENTERS	100.0/1	44 505 7/0	0.0075	10		04.00
	09100 EMERGENCY	109, 061					
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0077070			0	
	04050 CLI NI C	293, 063				0	
	04950 BI C	64	2, 108	l .		0	
	04954 PODI ATRY	0	536	0.0000	00 0	0	93. 05
	OTHER REIMBURSABLE COST CENTERS			I		1	05.00
	09500 AMBULANCE SERVICES	1 2/4 572	02 051 ///		_		95. 00
200.00	Total (lines 50 through 199)	1, 264, 572	83, 951, 666	1	0	l 0	200. 00

Heal th	Financial Systems F.	AYETTE REGIONAL	HEALTH SYSTEM		In Li€	eu of Form CMS-2	2552-10
APP0R	FLONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der C	CN: 15-0064	Peri od:	Worksheet D	
THROUG	GH COSTS				From 10/01/2016		
			Component	CCN: 15-T064	To 09/30/2017	Date/Time Pre 2/26/2018 10:	pared:
			Title	: XVIII	Subprovi der -	PPS	20 alli
			11 11 0	AVIII	IRF	113	
	Cost Center Description	Non Physician	Nursing School	Nursing Scho	ol Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
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
	OUTPATIENT SERVICE COST CENTERS						
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	93. 01
93.05	04954 PODI ATRY	0	0		0	0	93. 05
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0		0 0	0	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-0064   From 10/01/2016   Part IV Pate 1/V Departed: 2/26/2018 10: 28 am PPS   Title XVIII   Subprovider	Heal th	Financial Systems FA	AYETTE REGIONAL	. HEALTH SYSTEM		In Li€	eu of Form CMS-2	2552-10
THROUGH COSTS   Component CCN: 15-T064   From 10/01/2016   Part I V Till Prepared: 2726/2018 10: 28 am			RVICE OTHER PASS	S Provider Co	CN: 15-0064			
Title XVIII   Subprovider - IRF   PPS   IRF     Cost Center Description   All Other   Education Cost   Cost (sum of col 1 through col. 4)   Outpatient Cost (sum of col. 2, 3 and 4)   Part I, col. (col. 5 ÷ col. 7)   Part I, col. (col. 5 ÷ col. 7)   Part I, col. (col. 5 † col. 2, 3 and 4)   Part I, col. (col. 5 † col. 2, 23 and 4)   Part I, col. (col. 5 † col. 2, 23 and 4)   Part I, col. (col. 5 † col. 2, 23 and 4)   Part I, col. (col. 5 † col. 2, 23 and 4)   Part I, col. (col. 5 † col. 2, 23 and 4)   Part I, col. (col. 5 † col. 2, 23 and 4)   Part I, col. (col. 5 † col. 2, 23 and 4)   Part I, col. (col. 5 † col. 2, 23 and 4)   Part I, col. (col. 5 † col. 2, 23 and 24 † col. 20						From 10/01/2016	Part IV	
Title XVIII   Subprovider -   PPS				Component	CCN: 15-T064	To 09/30/2017	Date/Time Pre	pared:
All Other   Medical   Education Cost   Sum of coil 1   Cost (sum of coil 2, 3 and 4)   Total Charges (coil 5 ÷ coil . 7)   Cost (sum of coil 2, 3 and 4)   Total Charges (coil 5 ÷ coil . 7)   Cost (sum of coil 2, 3 and 4)   Cost (sum of coil 2, 3 and 4)   Total Charges (coil 5 ÷ coil . 7)   Cost (sum of coil 2, 3 and 4)   Cost (sum of coil 2, 3 an				Ti tl o	Y\/	Subprovi der -		28 alli
Medical Education Cost   Cost (sum of col 1 through col .   Cost (sum of col 2, 3 and 4)					XVIII	. I RF		
ANCILLARY SERVICE COST CENTERS     A		Cost Center Description						
A   Col   2, 3 and   8   7)								
A   O   S   O   O   O   O   O   O   O   O			Education Cost	through col.				
ANCI LLARY SERVI CE COST CENTERS				4)	· ·	(8 t	7)	
ANCI LLARY SERVI CE COST CENTERS   50.00   05000   07500   0								
50.00   05000   0PERATI NG ROOM   0   0   0   5,904,468   0.000000   50.00   54.00   54.00   65.00   65.00   65.00   66.00			4.00	5. 00	6.00	7. 00	8. 00	
54. 00			_	_	1			
60. 00			0	0				
65. 00			0	0				
66. 00			0	0				
69. 00	65.00	06500 RESPI RATORY THERAPY	0	0		0 3, 243, 536	0. 000000	65. 00
69. 01 06901 CARDI AC REHAB 0 0 0 457, 603 0. 000000 69. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 2, 282, 933 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 637, 133 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 9, 658, 580 0. 000000 73. 00  0017PATI ENT SERVI CE COST CENTERS  91. 00 09100 EMERGENCY 0 0 0 14, 505, 769 0. 000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 669, 396 0. 000000 93. 00 93. 01 04950 CLI NI C 0 0 0 5, 830, 412 0. 000000 93. 01 93. 05 04954 PODI ATRY 0 0 0 0 536 0. 000000 93. 05  075. 00 09500 AMBULANCE SERVI CES	66.00	06600 PHYSI CAL THERAPY	0	0		0 1, 873, 713	0.000000	66. 00
71. 00	69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0.000000	69. 00
72. 00	69. 01	06901 CARDI AC REHAB	0	0		0 457, 603	0.000000	69. 01
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   9,655,580   0.000000   73. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 2, 282, 933	0.000000	71.00
OUTPATIENT SERVICE COST CENTERS   O   O   O   O   O   O   O   O   O	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 637, 133	0.000000	72.00
91. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 9, 658, 580	0.000000	73. 00
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   669, 396   0.000000   92. 00   93. 00   04050   CLI NI C   0   0   0   5, 830, 412   0.000000   93. 00   93. 01   04950   BI C   0   0   0   0   2, 108   0.000000   93. 01   93. 05   04954   PODI ATRY   0   0   0   536   0.000000   93. 05    07   07   07   07   07   07   07   0		OUTPATIENT SERVICE COST CENTERS						
93. 00	91.00	09100 EMERGENCY	0	0		0 14, 505, 769	0.000000	91. 00
93. 01   04950   BI C   0   0   0   2, 108   0. 000000   93. 01   93. 05   04954   PODI ATRY   0   0   0   536   0. 000000   93. 05   04954   PODI ATRY   0   0   0   0   0   0   0   0   0	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 669, 396	0.000000	92.00
93. 05   04954   PODI ATRY   O   O   0   536   O. 000000   93. 05   OTHER REI MBURSABLE COST CENTERS   95. 00   O9500   AMBULANCE SERVI CES   95. 00   O9500   OSTANO   OSTANO	93.00	04050 CLI NI C	0	0		0 5, 830, 412	0.000000	93. 00
OTHER REIMBURSABLE COST CENTERS  95. 00   O9500   AMBULANCE SERVICES   95. 00	93. 01	04950 BI C	0	0		0 2, 108	0.000000	93. 01
95. 00 09500 AMBULANCE SERVICES 95. 00	93. 05	04954 PODI ATRY	0	0		0 536	0.000000	93. 05
200,00   Total (Lines 50 through 199)   0   0   83 951 666   200 00	95.00	09500 AMBULANCE SERVICES						95. 00
	200.00	Total (lines 50 through 199)	0	0		0 83, 951, 666		200. 00

Heal th	Fi nan	cial Systems FA	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	eu of Form CMS-:	2552-10
		IT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der Co	CN: 15-0064	Peri od:	Worksheet D	
THROUG	H COST	-S				From 10/01/2016		
				Component	CCN: 15-T064	To 09/30/2017	Date/Time Pre 2/26/2018 10:	
				Ti tl c	: XVIII	Subprovi der -	PPS	20 аш
				11 (1)	AVIII	IRF	113	
		Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
			Ratio of Cost	Program	Program	Program	Program	
			to Charges	Charges	Pass-Through	n Charges	Pass-Through	
			(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
			7)		x col. 10)		x col. 12)	
			9. 00	10. 00	11. 00	12. 00	13. 00	
	-	_ARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0. 000000	0		0	0	50. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	0. 000000	0		0	0	54.00
60.00	06000	LABORATORY	0. 000000	0		0	0	60.00
65.00	06500	RESPI RATORY THERAPY	0. 000000	0		0 0	0	65. 00
66.00	06600	PHYSI CAL THERAPY	0. 000000	0		0 0	0	66. 00
69. 00	06900	ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69. 00
69. 01	06901	CARDI AC REHAB	0.000000	0		0	0	69. 01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73. 00
	OUTPA <sup>-</sup>	TIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0. 000000	0		0 0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	0	92.00
93.00	04050	CLINIC	0. 000000	0		0 0	0	93.00
93. 01	04950	BIC	0. 000000	0		0 0	0	93. 01
93. 05	04954	PODI ATRY	0. 000000	0		0 0	0	93. 05
	OTHER	REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95. 00
200.00	)	Total (lines 50 through 199)		0		0 0	0	200. 00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0064	Peri od: From 10/01/2016	Worksheet D-1	
			Date/Time Pre 2/26/2018 10:	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			4 00	

		Title XVIII	Hospi tal	2/26/2018 10:	28 am
	Cost Center Description	II the Aviii	110Spi tai	FF3	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days	excluding newborn)		2, 254	1.00
2. 00	Inpatient days (including private room days, excluding swing-k			2, 254	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be			1, 763	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	om days) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	m days) arter becomber	or or the cost	ا	0.00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing_bod_and	835	9. 00
7. 00	newborn days)	The frogram (excruding	Swifig-bed and	033	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instruct				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (Therdaing privat	e room days)	1	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar ye				
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
	reporting period	o till dagi. December of er		J. 55	. ,
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions			2, 831, 075	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	2, 831, 073	22.00
	5 x line 17)		(	- 1	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	21 of the cost managet	na nominal (lina	0	24. 00
24.00	7 x line 19)	31 of the cost reporti	ng perrou (Trile	ا ا	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)			_	
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (	Tipo 21 minus Lipo 24)		0 2, 831, 075	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	Time 21 minus Time 20)		2, 831, 073	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 mir		tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x lin	ie 31)		0.00	35. 00 36. 00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fforontial (line	0 2, 831, 075	37.00
37.00	27 minus line 36)	and private room cost ar	Troncintial (TITIE	2,031,075	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see	*		1, 256. 02	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		1, 048, 777	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39)			0 1, 048, 777	40. 00 41. 00
11.00	1.0.ca rogical gonoral riputiont routine service cost (Tille 37		ı	1, 070, 777	1 11.00

	Financial Systems F ATION OF INPATIENT OPERATING COST	ATELIE REGIONAL	Provider CC		Peri od:	wof Form CMS-2 Worksheet D-1	
					From 10/01/2016 To 09/30/2017	Date/Time Pre	
			Title	XVIII	Hospi tal	2/26/2018 10: 2 PPS	28 am
	Cost Center Description	Total Inpatient Cost	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
42.00	MUDSEDY (+i+Lo V & VIV only)	1.00	2.00	3.00	4.00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units		0	0.0	<u>J</u>	U	42.00
43. 00	INTENSIVE CARE UNIT	1, 543, 787	271	5, 696. 6	169	962, 730	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					1, 169, 591	48. 00
49. 00	J (	41 through 48)(	see instructio	ns)		3, 181, 098	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D. sum	of Parts I and	163, 080	50. 00
	111)		•				
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	y services (fro	om Wkst. D, s	um of Parts II	50, 513	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				213, 593	52. 00
53. 00	Total Program inpatient operating cost exclu	9 1	lated, non-phys	sician anesth	etist, and	2, 967, 505	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)						55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (li	ne 56 minus	ine 53)	0	
58. 00	Bonus payment (see instructions)	Ü			ŕ	0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	endi ng 1996, u	odated and co	mpounded by the	0. 00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the ma	arket basket		0. 00	60.00
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x o	60), or 1% of	the target		
62. 00	Relief payment (see instructions)	•				0	
63. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
/F 00	instructions)(title XVIII only)	to often Decemb	or 21 of the e	ot monomting	nonind (Con		/E 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	its after Decemb	er 31 or the co	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31 of	the cost re	porting period	0	67. 00
	(line 12 x line 19)	3		'	5 1		07.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + line	68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N						
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	-					70.00 71.00
72. 00	Program routine service cost (line 9 x line	71)		,			72. 00
73. 00 74. 00	Medically necessary private room cost applic			ne 35)			73. 00 74. 00
75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient			orksheet B, Pa	art II, column		75.00
	26, line 45)		•				
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,					76. 00 77. 00
78. 00	, ,						78. 00
79.00	Aggregate charges to beneficiaries for exces			*	1: 70)		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ust iimitation	(IIIe /8 MIN	ıs iine /9)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	•				82. 00
83.00	Reasonable inpatient routine service costs (		s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84. 00 85. 00
	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
97 AA	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					491	87. 00
87. 00	Adjusted general inpatient routine cost per	•	line 2)			1, 256. 02	
88. 00	That disted general impatreme routine cost per	arciii (TTTIC 27 .	11110 2)				

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2016 To 09/30/2017		
		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	261, 740	2, 831, 075	0. 09245	3 616, 706	57, 016	90. 00
91.00 Nursing School cost	0	2, 831, 075	0.00000	0 616, 706	0	91.00
92.00 Allied health cost	0	2, 831, 075	0.00000	0 616, 706	0	92. 00
93 00 All other Medical Education	0	2 831 075	0 00000	616 706	0	93 00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0064	Peri od: From 10/01/2016	Worksheet D-1
	Component CCN: 15-S064	To 09/30/2017	Date/Time Prepared: 2/26/2018 10:28 am
	Title XVIII	Subprovi der -	PPS

		II the Aviii	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			2, 242	1. 00
2.00	Inpatient days (including private room days, excluding swing-			2, 242	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pri	vate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation be	ed davs)		2, 242	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period		24 6 11		, 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December .	31 of the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 3°	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 585	9. 00
	newborn days)	3	9	,	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		nom days) after	o	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	Join days) arter	ĭ	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	/ only (including private	room dove)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ve			٥	13.00
14.00	Medically necessary private room days applicable to the Progra		,	0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	f the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
17.00	reporting period	o tili dagii becember oi oi	1110 0031	0.00	17.00
20. 00	Medicald rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		2, 608, 660	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	2, 000, 000	22. 00
	5 x line 17)	•			
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reportin	na period (line	0	24. 00
	7 x line 19)		.9		
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20)   Total swing-bed cost (see instructions)			o	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 608, 660	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	ŕ		0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 00) (		0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin	, ,	tions)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	10 01 <i>)</i>		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	2, 608, 660	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 163. 54	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		1, 844, 211	39. 00
40.00	Medically necessary private room cost applicable to the Progra	•		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ II ne 4U)		1, 844, 211	41.00

		AYETTE REGIONAL				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider Component	CCN: 15-0064 CCN: 15-S064	Period: From 10/01/2016 To 09/30/2017		
			Ti tl e	e XVIII	Subprovi der -	2/26/2018 10: PPS	28 am_
	Cost Center Description	Total	Total	Average Per	. I PF	Program Cost	
	cost denter bescription	Inpatient Cost				(col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units			0.1	50  0	0	42.00
43.00	INTENSIVE CARE UNIT	0	O	0.	00	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	·					1.00	
48.00	Program inpatient ancillary service cost (Wk			>		342, 801	
49. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)(S	see instructio	ons)		2, 187, 012	49. 00
50.00	Pass through costs applicable to Program inp	atient routine s	services (from	n Wkst. D, sur	n of Parts I and	69, 867	50. 00
51. 00		atient ancillary	, services (fr	om Wkst D «	sum of Parts II	12, 123	51.00
	and IV)	-	, 30, 1, 603 (11	S III.S C. D,	or runts 11		
52. 00	Total Program excludable cost (sum of lines		atad nan nhu	oiaian anaati	actiot and	81, 990	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line !		ateu, non-pny		ictist, diu	2, 105, 022	53. 00
E 4 .00	TARGET AMOUNT AND LIMIT COMPUTATION						F 4 00
54. 00 55. 00	Program discharges Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operations	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	57. 00 58. 00
59. 00					ompounded by the	1	
	market basket						,,,,,,,
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0.00	1
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						
62. 00	amount (line 56), otherwise enter zero (see instructions)  Relief payment (see instructions)				0	62. 00	
	0 Allowable Inpatient cost plus incentive payment (see instructions)				0		
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  ON Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See				0	64.00	
	instructions)(title XVIII only)						
65. 00	65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	5)(title XVI	I only). For	0	66. 00
67 00	CAH (see instructions)				enorting period	0	67. 00
07.00	7.00   Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				sportring period	Ĭ	07.00
68. 00					0	68. 00	
69. 00	(line 13 x line 20)   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)			0	69. 00		
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY				1		70.00
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00	
72.00	Program routine service cost (line 9 x line 71)					72.00	
73. 00 74. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)					73. 00 74. 00	
75. 00	Capital-related cost allocated to inpatient	•			Part II, column		75. 00
76. 00	26, line 45)   Per diem capital-related costs (line 75 ÷ line 2)					76. 00	
77. 00	Program capital-related costs (line 9 x line 76)					77. 00	
78. 00 79. 00						78. 00 79. 00	
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80. 00	
81. 00 82. 00	Inpatient routine service cost per diem limitation					81.00	
82.00							82. 00 83. 00
84. 00	Program inpatient ancillary services (see instructions)						84. 00
85. 00 86. 00						85. 00 86. 00	
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	g 50 <i>)</i>				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			0 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see	•					89. 00
		•					

Health Financial Systems	FAYETTE REGIONAL	AYETTE REGIONAL HEALTH SYSTEM			In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1			
				From 10/01/2016				
		Component	CCN: 15-S064	To 09/30/2017	Date/Time Prep 2/26/2018 10:2			
		Title	XVIII	Subprovi der -	PPS	20 4111		
		11 11 0	AVIII	IPF	113			
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	98, 822	2, 608, 660	0. 03788	2 0	0	90.00		
91.00 Nursing School cost	0	2, 608, 660	0.00000	0	0	91.00		
92.00 Allied health cost	0	2, 608, 660	0.00000	0	0	92.00		
93.00 All other Medical Education	0	2, 608, 660	0.00000	0	0	93.00		

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0064		Worksheet D-1	
	Component CCN: 15-T064	From 10/01/2016 To 09/30/2017		
	Title XVIII	Subprovi der -	PPS	

		II tile XVIII	IRF	FF3	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			0	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-led and observation had day		vate room days	0	2. 00 3. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.				3.00
4.00	Semi-private room days (excluding swing-bed and observation be			0	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roof	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	udys) arter becomber	31 01 1110 0031	j	0.00
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	days) after December 2	1 of the cost	0	8. 00
6.00	reporting period (if calendar year, enter 0 on this line)	days) after becember 3	i or the cost	١	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	0	9. 00
40.00	newborn days)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruc-		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room davs)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye			_	
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
40.00	reporting period	CI D I 21 C		0.00	40.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	5)		7, 485	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
00.00	5 x line 17)	04 6 11			00.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December $(x, y)$	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 485	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				20.00
28.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	28. 00 29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	ous line 33)(see instruc	tions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin		LI UIIS)	0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	7, 485	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			0. 00	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			0	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0	40. 00 41. 00
41.00	Tiotal Trogram general impatrent routine service cost (IIIIe 39	1 11110 40)	ı	υĮ	41.00

		AYETTE REGIONAL				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider Component	CCN: 15-0064 CCN: 15-T064	Peri od: From 10/01/2016 To 09/30/2017	Date/Time Pre	pared:
			Title	e XVIII	Subprovi der -	2/26/2018 10: PPS	28 am
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	·	Inpatient Cost	Inpatient Days			(col. 3 x col. 4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	O	0.0	00 0	0	43.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description			l		1.00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	, line 200)			1.00	48. 00
49. 00				ons)		0	49. 00
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sur	n of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	0	51. 00
52.00	Total Program excludable cost (sum of lines!					0	
53. 00	Total Program inpatient operating cost excluded medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		lated, non-phy	rsician anesti	netist, and	0	53. 00
54.00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	porting period	endi na 1996. u	updated and co	ompounded by the	0.00	
	market basket	0.		•	. ,		
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						0.00	1
42.00	amount (line 56), otherwise enter zero (see i		s (IInes 54 X	60), or 1% of	r the target		(2.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	cost reportino	g period (See	0	65. 00
66. 00		ne costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili				)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00
73. 00	·	•	(line 14 x li	ne 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine servicapital-related cost allocated to inpatient	•			Part II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital related costs (line 75 ÷ line						76.00
77. 00 78. 00							77. 00 78. 00
79.00	Aggregate charges to beneficiaries for excess				aug Line 70)		79. 00 80. 00
80. 00 81. 00	Total Program routine service costs for comparing the routine service cost per diem limit		ost iimi tati 01	. (11116 /0 IIII	ius IIIIe /9)		81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (		* .				82. 00 83. 00
84. 00	Program inpatient ancillary services (see ins		<i>J</i>				84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	. Jugir 00 <i>)</i>				1
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of		line 2)			0.00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see	•	•				89. 00

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM		In Lie	2552-10	
COMPUTATION OF INPATIENT OPERATING COST				Peri od:	Worksheet D-1	
				From 10/01/2016		
		Component	CCN: 15-T064	To 09/30/2017	Date/Time Prep 2/26/2018 10:2	oarea: 28 am
		Title	XVIII	Subprovi der -	PPS	20 am
			,,,,,,	I RF		
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	28	7, 485	0. 00374	1 0	0	90.00
91.00 Nursing School cost	0	7, 485	0. 00000	0	0	91.00
92.00 Allied health cost	0	7, 485	0. 00000	0	0	92.00
93.00 All other Medical Education	0	7, 485	0. 00000	0	0	93.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	Inlie	u of Form CMS-2	2552_10
				2332-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0064	Peri od:	Worksheet D-1	
		From 10/01/2016		
		To 09/30/2017	Date/Time Pre	nared·
		77 007 2017	2/26/2018 10:	
	Title XIX	Hospi tal	Cost	
Cost Center Description				
			1. 00	
DART I ALL PROVIDED COMPONENTS	·			

		Title XIX	Hospi tal	2/26/2018 10:: Cost	28 am_
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-k			2, 254 2, 254	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	3 /	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		1, 763	4. 00
5.00	Total swing-bed SNF type inpatient days (including private rooreporting period		r 31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 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
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swi ng-bed and	68	9. 00
10. 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
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			324 24	
10.00	SWING BED ADJUSTMENT			27	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0. 00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19. 00
20. 00	Medical d rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		2, 831, 075	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	line 21 minus line 26)		2, 831, 075	27. 00
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 =	line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	1111C 20)		0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lir		<i>,</i>	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 a	and private room cost di	fferential (line	2, 831, 075	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 256. 02	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		85, 409	
40. 00	Medically necessary private room cost applicable to the Progra	•		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)	ļ	85, 409	41. 00

Heal th	h Financial Systems FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST Provider CCN: 15-0064 Perior	od: 10/01/2016	Worksheet D-1	
		09/30/2017	Date/Time Prep 2/26/2018 10:2	
		ospi tal	Cost	EO GIII
	Cost Center Description   Total   Total   Average Per   Pro	ogram Days	Program Cost (col. 3 x col.	
	col. 2)		4)	
42. 00	1.00 2.00 3.00 NURSERY (title V & XIX only) 704,501 324 2,174.39	4. 00	5. 00 52, 185	42. 00
	Intensive Care Type Inpatient Hospital Units			
43. 00 44. 00		0	0	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT			45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)			46. 00 47. 00
	Cost Center Description		4.00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		1. 00 142, 076	48. 00
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS		279, 670	49. 00
50.00		arts I and	0	50. 00
51. 00		Parts II	0	51. 00
	and IV)			
52. 00 53. 00	, ,	: and	0	52. 00 53. 00
	medical education costs (line 49 minus line 52)	,	_	
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION  Program discharges		0	54. 00
55.00				55.00
56. 00 57. 00		53)	0	56. 00 57. 00
58. 00 59. 00		adad by the	0 00	58. 00 59. 00
59.00	market basket	ded by the		39.00
60. 00 61. 00		amount by	0. 00 0	60. 00 61. 00
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the		O .	01.00
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions)		0	62. 00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting pe	eriod (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting peri	od (See	0	65. 00
	instructions)(title XVIII only)	.		
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII onl CAH (see instructions)	y). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporti	ng period	0	67. 00
68. 00	(line 12 x line 19)   Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting	g period	0	68. 00
69. 00	(line 13 x line 20)   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		0	69. 00
	PART III - SKILLED NURSINĞ FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		Ü	
70. 00 71. 00				70. 00 71. 00
72. 00 73. 00	Program routine service cost (line 9 x line 71)			72. 00
74. 00				73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part I 26, line 45)	I, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ line 2)			76. 00
77. 00 78. 00				77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)			79. 00
80. 00 81. 00		ne 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (line 9 x line 81)			82. 00
83. 00 84. 00				83. 00 84. 00
85. 00	Utilization review - physician compensation (see instructions)			85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST			86. 00
87.00	Total observation bed days (see instructions)		491	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)		1, 256. 02 616, 706	
		•	·	

Health Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC	Provider CCN: 15-0064 F		Worksheet D-1	
				To 09/30/2017	Date/Time Prep 2/26/2018 10:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	261, 740	2, 831, 075	0. 09245	3 616, 706	57, 016	90.00
91.00 Nursing School cost	0	2, 831, 075	0.00000	616, 706	0	91.00
92.00 Allied health cost	0	2, 831, 075	0.00000	616, 706	0	92.00
93.00 All other Medical Education	0	2, 831, 075	0.00000	616, 706	0	93.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0064	Peri od: From 10/01/2016	Worksheet D-1
	Component CCN: 15-S064	To 09/30/2017	Date/Time Prepared: 2/26/2018 10:28 am
	Title XIX	Subprovi der -	Cost

		II LIE XIX	I PF	COST	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			2, 242	
2.00	Inpatient days (including private room days, excluding swing-b			2, 242	2.00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 242	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5. 00
	reporting period				,
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	davs) through December	31 of the cost	0	7. 00
	reporting period	3 .			
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (eycluding	swing-bed and	195	9. 00
7.00	newborn days)	the frogram (excruding	Swifig-bed and	173	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
44.00	through December 31 of the cost reporting period (see instruct				44 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) arter	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(		324	
16. 00	Nursery days (title V or XIX only)			24	16. 00
17 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	as through December 21 or	f the cost	0.00	17 00
17. 00	reporting period	es through December 31 of	r the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period			0.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	tne cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing ported (line	2, 608, 660	21. 00 22. 00
22.00	5 x line 17)	er 31 of the cost report	riig perrou (iriie	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
04.00	x line 18)	04 6 11			04.00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ line 19)	31 of the cost reportii	ng perioa (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00 27. 00	Total swing-bed cost (see instructions)	(line 21 minus line 24)		0 2, 608, 660	26.00
27.00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	Title 21 IIII lus Title 20)		2, 606, 660	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 35)	ie 31)		0.00	35. 00 36. 00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 2, 608, 660	
37.00	27 minus line 36)	and private room cost ur	Transmittan (Title	2, 300, 000	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 163. 54	
39. 00	Program general inpatient routine service cost (line 9 x line			226, 890	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 226, 890	40.00
11.00	1.5ta sgram general impatreme routine service cost (fille 37		'	220, 070	

		AYETTE REGIONAL				eu of Form CMS-2	
COMPUTA	ATION OF INPATIENT OPERATING COST		Provider Component	CCN: 15-0064 CCN: 15-S064	Peri od: From 10/01/2016 To 09/30/2017	Date/Time Pre	pared:
			Ti tl	e XIX	Subprovi der -	2/26/2018 10: Cost	28 am
	Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
	·	Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 00	5.00	42.00
	Intensive Care Type Inpatient Hospital Units	-1		-			
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0.	00	0	43.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description	· · · · · · · · · · · · · · · · · · ·				1.00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	, line 200)			1. 00 70, 357	48. 00
	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS			ns)		297, 247	49. 00
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, su	m of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpaland IV)	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	0	51. 00
52.00	Total Program excludable cost (sum of lines!					0	
53. 00	Total Program inpatient operating cost excluded medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		lated, non-phy	'sıcıan anest	netist, and	0	53. 00
	Program di scharges					0	
	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	57. 00
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996, u	pdated and c	ompounded by the	0.00	
60. 00	market basket	rost renort un	dated by the m	arket hasket		0.00	60.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						0.00	
amount (line 56), otherwise enter zero (see instructions)							(2.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost report	ing period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reportin	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	f the cost r	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient   PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
	Skilled nursing facility/other nursing facili	ty/ICF/IID rou	tine service c	ost (line 37	)		70. 00
	Adjusted general inpatient routine service co Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applica	able to Program	•				73. 00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient in 26 June 45)	•			Part II, column		74. 00 75. 00
	26, line 45) Per diem capital-related costs (line 75 ÷ line						76.00
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
	Aggregate charges to beneficiaries for excess				nuo lino 70)		79. 00 80. 00
80. 00 81. 00	Total Program routine service costs for compa- Inpatient routine service cost per diem limi		ost iimi tati On	(11116 /0 1111	1110 11110 /9)		81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (		•				82. 00 83. 00
84. 00	Program inpatient ancillary services (see ins		<i>,</i>				84. 00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST	1 Jugii 00)				
87. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of		line 2)			0,00	87. 00 88. 00
88. 00							

Health Financial Systems	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	2552-10	
COMPUTATION OF INPATIENT OPERATING COST				Peri od:	Worksheet D-1	
		C		From 10/01/2016		
		Component	CCN: 15-S064	To 09/30/2017	Date/Time Prep 2/26/2018 10:2	
		Titl	e XIX	Subprovi der -	Cost	LO UIII
				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						
90.00 Capital -related cost	98, 822	2, 608, 660	0. 03788	2 0	0	90.00
91.00 Nursing School cost	0	2, 608, 660	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 608, 660	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 608, 660	0. 00000	0	0	93.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0064	Peri od:	Worksheet D-3	
			From 10/01/2016 To 09/30/2017	Date/Time Pre 2/26/2018 10:	pared 28 am
	Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
·		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00   03000   ADULTS & PEDI ATRI CS			1, 233, 649		30.0
1.00   03100   INTENSIVE CARE UNIT			488, 711		31. (
0. 00   04000   SUBPROVI DER - 1 PF			0		40.
1. 00   04100   SUBPROVI DER - I RF			0		41.
2. 00   04200   SUBPROVI DER			0		42.
3. 00   04300   NURSERY					43.
ANCI LLARY SERVI CE COST CENTERS					
0.00   05000   OPERATING ROOM		0. 42174		106, 466	
4. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 2016		181, 239	
0. 00   06000   LABORATORY		0. 18664		200, 005	
5. 00   06500   RESPI RATORY THERAPY		0. 2706		154, 793	
6. 00   06600   PHYSI CAL THERAPY		0. 59519		37, 079	
9. 00   06900   ELECTROCARDI OLOGY		0.00000		0	1
9. 01   06901   CARDI AC REHAB		0. 98697		0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 49004		131, 974	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 56324		1, 884	
3.00 O7300 DRUGS CHARGED TO PATIENTS		0. 33352	26 713, 235	237, 882	73.
OUTPATIENT SERVICE COST CENTERS					
1. 00   09100   EMERGENCY		0. 18270		117, 993	
2.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		0. 92128		0	
3. 00   04050   CLI NI C		0. 8134		276	
3. 01   04950   BI C		8. 12428		0	
3. 05   04954   PODI ATRY		0. 01492	25 0	0	93.
OTHER REI MBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVICES					95.
00.00 Total (sum of lines 50 through 94 and 96 through 98)			4, 488, 900	1, 169, 591	
01.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.
02.00 Net charges (line 200 minus line 201)			4, 488, 900		202.

	<del></del>	GIONAL HEALTH SYSTEM			u of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0064	Peri od:	Worksheet D-3	
		Component	CCN: 15-S064	From 10/01/2016 To 09/30/2017	Date/Time Pre	narad.
		Component	CCN: 15-5064	To 09/30/2017	2/26/2018 10:	
		Title	: XVIII	Subprovi der -	PPS	20 4111
				IPF		
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDIATRICS			0		30. 00
31. 00	03100   I NTENSI VE CARE UNI T			0		31. 00
	04000 SUBPROVI DER - I PF			2, 739, 511		40. 00
41. 00	04100 SUBPROVI DER - I RF			0		41. 00
42.00	04200 SUBPROVI DER			0		42. 00
43. 00	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS					
50. 00	05000 OPERATING ROOM		0. 4217			
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 2016		30, 453	1
60. 00	06000 LABORATORY		0. 1866		53, 453	
65. 00	06500 RESPI RATORY THERAPY		0. 2706		1, 654	65. 00
66. 00	06600 PHYSI CAL THERAPY		0. 5951		71, 317	66. 00
69. 00	06900 ELECTROCARDI OLOGY		0.0000		0	69. 00
69. 01	06901 CARDI AC REHAB		0. 9869		0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 49004		2, 439	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 5632		0	72.00
/3.00	07300 DRUGS CHARGED TO PATIENTS		0. 3335	26 491, 745	164, 010	73. 00
01 00	OUTPATIENT SERVICE COST CENTERS  O9100 EMERGENCY		0 1007	10/ 401	10.455	01 00
			0. 18270		19, 455	91. 00 92. 00
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 92128		0	92.00
93. 00			0.8134		_	93.00
	04950 BI C		8. 12428		0	93.01
93. 05	OTHER REIMBURSABLE COST CENTERS		0. 01492	20  0	0	73.05
95. 00	09500 AMBULANCE SERVICES					95. 00
200.00		h 08)		1, 166, 577	342, 801	
200.00				1, 100, 377		200.00
201.00		y charges (Title 01)		1, 166, 577		201.00
202.00	The sharges (Title 200 millios Title 201)		1	1, 100, 377	ı	1202.00

Health Financial Systems FAYETTE REGIONAL INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0064		eu of Form CMS- Worksheet D-3	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0064	Peri od: From 10/01/2016	worksneet D-3	
			To 09/30/2017	Date/Time Pre 2/26/2018 10:	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS			47, 316		30.00
31. 00   03100   I NTENSI VE CARE UNI T			7, 547		31.00
40. 00   04000   SUBPROVI DER - 1 PF			0		40.00
41. 00   04100   SUBPROVI DER - I RF			0		41.00
42. 00   04200   SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			15, 716		43.00
ANCI LLARY SERVI CE COST CENTERS				T	
50. 00   05000 OPERATI NG ROOM		0. 42174		· ·	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2016		· ·	
60. 00   06000   LABORATORY		0. 1866		· ·	
65. 00 06500 RESPI RATORY THERAPY		0. 2706			
66. 00   06600 PHYSI CAL THERAPY		0. 59519		0	00. 00
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	
69. 01 06901 CARDI AC REHAB		0. 98697		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 49004			
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 56324		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 33352	26 102, 602	34, 220	73.00
OUTPATIENT SERVICE COST CENTERS				10.010	
91. 00 09100 EMERGENCY		0. 18270		12, 312	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 92128		0	1
93. 00   04050   CLI NI C		0. 78746		0	
93. 01   04950 BI C		8. 12428		0	93. 0
93. 05   04954   PODI ATRY		0. 01492	25 0	0	93. 05
OTHER REIMBURSABLE COST CENTERS					05 0.
95. 00   09500   AMBULANCE SERVI CES			F00 700	440.077	95. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		1	533. 798	142. 076	1200. ()(

533, 798 0

533, 798

142, 076 200. 00 201. 00 202. 00

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

200. 00 201. 00 202. 00

	nancial Systems FAYETTE REGIONAL I	_			u of Form CMS-	
I NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0064	Peri od:	Worksheet D-3	
		Component	CCN: 15-S064	From 10/01/2016 To 09/30/2017	Date/Time Pre	narod:
		Component	CCN. 15-3004	10 09/30/2017	2/26/2018 10:	
		Ti tl	e XIX	Subprovi der -	Cost	
				I PF		
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	ATIENT ROUTINE SERVICE COST CENTERS					
	000 ADULTS & PEDI ATRI CS			0		30.00
	OO I NTENSI VE CARE UNI T			0		31.00
	000 SUBPROVI DER - I PF			42, 241		40.00
	OO SUBPROVI DER - I RF			0		41.00
	OO SUBPROVI DER			0		42.00
	NURSERY			0		43. 00
	ILLARY SERVICE COST CENTERS OO OPERATING ROOM		0.4017	4.2		50.00
	100 RADI OLOGY-DI AGNOSTI C		0. 4217 0. 2016		0	
	100 LABORATORY		0. 2016	· ·	6, 431 10, 511	60.00
	100 RESPI RATORY THERAPY		0. 1806		0,511	1
	000 PHYSI CAL THERAPY		0. 2700		14, 305	
	100 ELECTROCARDI OLOGY		0.0000		14, 303	1
	001 CARDI AC REHAB		0. 9869		0	
	OO MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4900		468	
4	200 IMPL. DEV. CHARGED TO PATIENTS		0. 5632		0	
	DOU DRUGS CHARGED TO PATIENTS		0. 3335		33, 677	
	PATIENT SERVICE COST CENTERS		0.0000	100,771	00,011	70.00
	OO EMERGENCY		0. 1827	09 27, 176	4, 965	91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)		0. 9212		0	1
	050 CLI NI C		0. 7874		0	1
93. 01 049	050 BI C		8. 1242	38 0	0	93. 01
93. 05 049	54 PODI ATRY		0. 0149		0	93. 05
ОТН	ER REIMBURSABLE COST CENTERS			•		1
95. 00 095	OO AMBULANCE SERVICES					95. 00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			241, 343	70, 357	200. 00
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)			241, 343		202. 00

	Financial Systems FAYETTE REGIONAL F	_			u of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 10/01/2016	Worksheet D-3	
		Component	CCN: 15-U064	To 09/30/2017	Date/Time Prep 2/26/2018 10:	
		Ti tl	e XIX	Swing Beds - SNF	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			0		30. 00
31. 00	03100 I NTENSI VE CARE UNIT			0		31.00
40.00	04000 SUBPROVI DER - I PF			0		40. 00
41. 00	04100 SUBPROVI DER - I RF			0		41.00
42.00	04200 SUBPROVI DER			0		42. 00
43.00	04300 NURSERY			0		43. 00
	ANCI LLARY SERVI CE COST CENTERS					
50. 00	05000 OPERATING ROOM		0. 42174		0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 20167		0	54.00
60.00	06000 LABORATORY		0. 18664		0	60.00
	06500 RESPI RATORY THERAPY		0. 27067		0	65. 00
	06600 PHYSI CAL THERAPY		0. 59519		0	66. 00
	06900 ELECTROCARDI OLOGY		0.00000		0	69. 00
	06901 CARDI AC REHAB		0. 98697		0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 49004		0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 56324		0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 33352	26 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS					
	09100 EMERGENCY		0. 18270		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 92128		0	92. 00
	04050 CLI NI C		0. 78746		0	93. 00
	04950 BI C		8. 12428		0	93. 01
93. 05	04954 PODI ATRY		0. 01492	25 0	0	93. 05
	OTHER REIMBURSABLE COST CENTERS		1			
OF OO	DOEGO AMPLII ANCE SERVI CES		I	1		95 00

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

95.00

0 200. 00 201. 00 202. 00

0 0 0

95. 00 09500 AMBULANCE SERVICES

200. 00 201. 00 202. 00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0064	Peri od: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/26/2018 10:28 am

PART A - IMPATIENT HISSPITAL SERVICES LIMBER I PPS   1.00			Ti +1 o V/// /	Hospi tol	2/26/2018 10: PPS	28 am
PART A - INPATIENT MOSPITAL SERVICES UNDER IPPS			Title XVIII	Hospi tal	PPS	
DRC Amounts other than outlier Payments For discharges occurring prior to October 1 (see   0   1.01					1. 00	
1.00   DRC amounts other than outlier payments for discharges occurring on or after October 1 (see   1,630.424   1.02   1.03   DRC amounts other than outlier payments for discharges occurring on or after October 1 (see   1,630.424   1.02   1.03   DRC amounts other than outlier payments for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)   1.04   DRC for federal specific operating payment for Model 4 BPCI for discharges occurring on or after   0   1.04   DRC for federal specific operating payment for Model 4 BPCI for discharges occurring on or after   0   1.04   DRC for federal specific operating payment for discharges (see instructions)   25,767   2.00   2.01   2.	1 00				0	1 00
DRC amounts other than outlier payments for discharges occurring on or after October 1 (see   1,630.424   1.02		DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (s	see	-	
1.03   ORC for Federal specific operating payment for Model 4 BPCI for discharges occurring prior to October   0   1.03	1. 02	DRG amounts other than outlier payments for discharges occurri	ng on or after October	1 (see	1, 630, 424	1. 02
1.04   Oktober 1 (see Instructions)   2.5, 747   2.00   Outplier payments for discharges, (see instructions)   2.5, 747   2.00   Outplier payments for discharges, (see instructions)   2.5, 747   2.00   Outplier payments for discharges, (see instructions)   2.02   2.01   Outplier payment for discharges for Model 4 BPCI (see instructions)   2.02   2.	1. 03	DRG for federal specific operating payment for Model 4 BPCI fo	r discharges occurring p	orior to October	0	1. 03
2.00         OutFlier payments for discharges. (see instructions)         25,767         2.00           2.01         OutFlier reconcilitation amount         0         2.01           2.00         DutFlier reconcilitation amount         0         2.02           2.00         DutFlier reconcilitation amount         0         2.02           2.00         Damaged Care Simulated Payments         0         3.00           4.00         Bed days available divided by number of days in the cost reporting period (see instructions)         3.00           5.00         The Count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)         0.00         6.00           6.00         Fice fount for all opathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)         7.00         MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(i)(8)(2)(f)         0.00         7.00           7.01         Cost feoret strated Subjuty 1.2011 then see instructions.         0.00         7.00         7.00         AG \$5000 reduction amount to the FFE count for all opathic and osteopathic programs for contributions.         0.00         7.00         7.01         7.01         7.01         7.01         7.01         7.01         7.01         7.01         7.01         7.01	1. 04	DRG for federal specific operating payment for Model 4 BPCI fo	r discharges occurring o	on or after	0	1. 04
Managed Car'e Simulated Payments   3.0		Outlier payments for discharges. (see instructions)				
8ed days available divided by number of days in the cost reporting period (see instructions)	2.02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02
Indirect Medical Education Adjustment   Country of allopathic and osteopathic programs for the most recent cost reporting period ending on property of the most process of the most recent cost reporting period ending on property of the most process of the most recent cost reporting period ending on property of the most process of the		o ,			- 1	
or before 12/31/1996, (see instructions)  10		Indirect Medical Education Adjustment				
For new programs in accordance with 42 CFR 413.79(e)   No. 00   No. 00   No. 00   No. 00   No. 00   ACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the		or before 12/31/1996. (see instructions)				
ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(0)(8)(2) if the cost report straidle as July 1, 2011 then see instructions.		for new programs in accordance with 42 CFR 413.79(e)		·		
Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.79(c).2(iv). d4 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		ACA § 5503 reduction amount to the IME cap as specified under				
8. 01   The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradies July 1, 2011, see instructions.   8. 01	8. 00	Adjustment (increase or decrease) to the FTE count for allopat affiliated programs in accordance with 42 CFR 413.75(b), 413.7			0.00	8. 00
8. 02   The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 ACA. (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slo	ts under § 5503 of the A	ACA. If the cost	0.00	8. 01
Instructions   10.00   TEC count for all opathic and osteopathic programs in the current year from your records   0.00   10.00	8. 02	The amount of increase if the hospital was awarded FTE cap slo	ts from a closed teachi	ng hospital	0. 00	8. 02
11.00   FTE count for residents in dental and podiatric programs.   0.00   11.00   12.00   12.00   13.00   10.01   10.00   10.00   12.00   10.00   1	9. 00		s (8, 8,01 and 8,02) (	see	0. 00	9. 00
13.00   Total all owable FTE count for the prior year.   0.00   13.00   14.00   Total all owable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero.   0.00   14.00	11. 00	FTE count for residents in dental and podiatric programs.	nt year from your record	ds	0. 00	11. 00
14.00		· · · · · · · · · · · · · · · · · · ·				
15.00   Sum of lines 12 through 14 divided by 3.   0.00   15.00   16.00   Adjustment for residents in initial years of the program   0.00   16.00   17.00   18.00   19.00		Total allowable FTE count for the penultimate year if that yea	r ended on or after Sep	tember 30, 1997,		
17.00       Adjustment for residents displaced by program or hospital closure       0.00       17.00         18.00       Adjusted rolling average FTE count       0.00       18.00         19.00       Current year resident to bed ratio (line 18 divided by line 4).       0.000000       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.000000       20.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       21.00         22.01       IME payment adjustment (see instructions)       0.22.00         22.01       IME payment adjustment - Managed Care (see instructions)       0.22.00         23.00       Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105       0.00         24.00       IME FTE Resident Count Over Cap (see instructions)       0.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000         27.00       IME payments adjustment factor. (see instructions)       0.000000         28.01       IME add-on adjustment amount (see instructions)       0.000000         28.01       IME add-on adjustment amount - Managed Care (see instructions)       0.29.00         29.00	15.00				0.00	15. 00
18.00       Adjusted rolling average FTE count       0.00       18.00         19.00       Current year resident to bed ratio (line 18 divided by line 4).       0.000000       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.000000       20.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       21.00         22.01       IME payment adjustment (see instructions)       0.22.00         1 ME payment adjustment - Managed Care (see instructions)       0.22.01         1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA       0.00         23.00       Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105       0.00       23.00         (f)(1)(iv)(c).       0.1       0.00       24.00       25.00       16 the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00       25.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00       25.00         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00         27.00       IME payments adjustment amount (see instructions)       0.000000       27.00         28.01       IME add-on adjustment factor. (see instructions)       0.2						
19.00 Current year resident to bed ratio (line 18 divided by line 4). 20.00 Prior year resident to bed ratio (see instructions) 21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.00 IME payment adjustment (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount - Managed Care (see instructions) 29.01 IME add-on adjustment amount - Managed Care (see instructions) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Sum of lines 30 and 31 42.62 32.00 33.00 Allowable disproportionate share percentage (see instructions) 20.00 33.00			ure			
20.00   Prior year resident to bed ratio (see instructions)   0.000000   20.00   21.00   22.00   Enter the lesser of lines 19 or 20 (see instructions)   0.000000   21.00   22.00   1ME payment adjustment (see instructions)   0.22.00   1ME payment adjustment (see instructions)   0.22.01   1ME payment adjustment - Managed Care (see instructions)   0.22.01   1ME payment adjustment - Managed Care (see instructions)   0.22.01   1ME payment adjustment for the Add-on for § 422 of the MMA   23.00   1ME FTE Resident Count Over Cap (see instructions)   0.00   23.00   (F) (1) (iv) (C) .   24.00   1ME FTE Resident Count Over Cap (see instructions)   0.00   24.00   25.00   1F the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see   0.00   25.00   1F the amount on line 24 is greater than +0-, then enter the lower of line 23 or line 24 (see   0.00   25.00   1ME payments adjustment factor. (see instructions)   0.000000   27.00   1ME payments adjustment factor. (see instructions)   0.000000   27.00   28.00   1ME add-on adjustment amount (see instructions)   0.28.00   28.01   1ME add-on adjustment amount - Managed Care (see instructions)   0.29.00   29.00   10   1ME payment - Managed Care (see instructions)   0.00000   29.0		,				
21.00 Enter the lesser of lines 19 or 20 (see instructions)  22.00 IME payment adjustment (see instructions)  22.01 IME payment adjustment - Managed Care (see instructions)  1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.01 IME add-on adjustment amount (see instructions)  29.01 Total IME payment - Managed Care (see instructions)  20.02 Exponents adjustment amount - Managed Care (see instructions)  20.03 IME add-on adjustment amount - Managed Care (see instructions)  29.01 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Sum of lines 30 and 31  41.00 Sum of lines 30 and 31  Allowable disproportionate share percentage (see instructions)  21.00 0.0000000 27.00  22.01 0.000000 23.00  23.00 21.00  24.00 0.000000 24.00  25.00 0.000000 26.00  26.00 0.000000 27.00  27.00 0.000000 27.00  28.01 0.000000 27.00  28.01 0.000000 27.00  29.00 0.000000 27.00  29.00 0.000000 27.00  29.00 0.000000 27.00  29.00 0.000000 27.00  29.00 0.000000 27.00  29.00 0.000000 27.00  20.0000000 27.00  20.000000 27.00  20.000000 27.00  20.000000 27.00  20.0						
22.00   IME payment adjustment (see instructions)   0   22.00     IME payment adjustment - Managed Care (see instructions)   0   22.01     Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA     23.00   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105   0.00   23.00     (f)(1)(iv)(C)		· · · · · · · · · · · · · · · · · · ·				
22.01   IME payment adjustment - Managed Care (see instructions)   0   1ndi rect Medical Education Adjustment for the Add-on for § 422 of the MMA   23.00   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105   0.00   23.00   (f)(1)(iv)(C)   0   0   0   0   0   0   0   0   0						
23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f) (1) (iv) (C).  24. 00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions)  26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 0.29.00 Total IME payment (sum of lines 22 and 28) 0.29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.29.01 Disproportionate Share Adjustment  30.00 Percentage of SI recipient patient days to Medicare Part A patient days (see instructions) 5.27 30.00 31.00 Sum of lines 30 and 31 42.62 32.00 33.00 Allowable disproportionate share percentage (see instructions) 12.00 33.00	22. 01				0	22. 01
(f)(1)(iv)(C).  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount (see instructions)  29.00 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Sum of lines 30 and 31  42.62 32.00  31.00 Allowable disproportionate share percentage (see instructions)  12.00 33.00				-D 440 405	0.00	
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 31.00 Jacob Allowable disproportionate share percentage (see instructions) 32.00 Jacob Allowable disproportionate share percentage (see instructions) 32.00 Jacob Allowable disproportionate share percentage (see instructions) 33.00 Jacob Allowable disproportionate share percentage (see instructions) 35.00 Jacob Allowable disproportionate share percentage (see instructions)		(f)(1)(iv)(C).	ent cap siots under 42 Cl	-R 412. 105		
26. 00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26. 00         27. 00       IME payments adjustment factor. (see instructions)       0.000000       27. 00         28. 00       IME add-on adjustment amount (see instructions)       0       28. 00         28. 01       IME add-on adjustment amount - Managed Care (see instructions)       0       28. 01         29. 00       Total IME payment (sum of lines 22 and 28)       0       29. 00         29. 01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       0       29. 01         Disproportionate Share Adjustment       30. 00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       5. 27       30. 00         31. 00       Percentage of Medicaid patient days (see instructions)       37. 35       31. 00         32. 00       Sum of lines 30 and 31       42. 62       32. 00         33. 00       Allowable disproportionate share percentage (see instructions)       12. 00       33. 00		If the amount on line 24 is greater than -O-, then enter the I	ower of line 23 or line	24 (see		
27.00       IME payments adjustment factor. (see instructions)       0.000000       27.00         28.00       IME add-on adjustment amount (see instructions)       0.28.00         28.01       IME add-on adjustment amount - Managed Care (see instructions)       0.28.01         29.00       Total IME payment (sum of lines 22 and 28)       0.29.00         29.01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       0.00         Disproportionate Share Adjustment       30.00         31.00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       5.27       30.00         31.00       Percentage of Medicaid patient days (see instructions)       37.35       31.00         32.00       Sum of lines 30 and 31       42.62       32.00         33.00       Allowable disproportionate share percentage (see instructions)       12.00       33.00	26 00				0 000000	26 00
28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 0 29. 00 Total IME payment - Managed Care (sum of lines 22. 01 and 28. 01) 0 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 5. 27 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 37. 35 31. 00 32. 00 Sum of lines 30 and 31 42. 62 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 12. 00 33. 00		the contract of the contract o				
28. 01 IME add-on adjustment amount - Managed Care (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  32. 00 33. 00		· · · · · · · · · · · · · · · · · · ·				
29. 00 Total IME payment (sum of lines 22 and 28) 0 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29. 01 Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 5. 27 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 37. 35 31. 00 32. 00 Sum of lines 30 and 31 42. 62 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 12. 00 33. 00		· · · · · · · · · · · · · · · · · · ·				
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  30. 00 Percentage of Medicaid patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Percentage of Medicaid patient days (see instructions)  33. 00 Percentage of Medicaid patient days (see instructions)  34. 62 Sum of lines 30 and 31  35. 00 Percentage of Medicaid patient days (see instructions)						
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  30.00 Sum of lines 30 and 31  42.62 32.00  33.00 Allowable disproportionate share percentage (see instructions)		Total IME payment - Managed Care (sum of lines 22.01 and 28.01	)		-	
31.00Percentage of Medicaid patient days (see instructions)37.3531.0032.00Sum of lines 30 and 3142.6232.0033.00Allowable disproportionate share percentage (see instructions)12.0033.00	30.00	Percentage of SSI recipient patient days to Medicare Part A pa	tient days (see instruc	tions)	5. 27	30. 00
33.00 Allowable disproportionate share percentage (see instructions) 12.00 33.00	31.00	Percentage of Medicaid patient days (see instructions)			37. 35	31. 00
34.00   Disproportionate share adjustment (see instructions) 48,913   34.00						
	34. 00	Disproportionate share adjustment (see instructions)		l	48, 913	34.00

	Financial Systems FAYETTE REGIONAL			u of Form CMS-2	2552-10
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0064	Peri od: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prep 2/26/2018 10:2	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
	Uncompensated Care Adjustment				
35. 00	Total uncompensated care amount (see instructions)		0		
35. 01	Factor 3 (see instructions)		0. 000000000	0. 000040126	35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero, ent instructions)	er zero on this line) (se	e   0	239, 852	35. 02
35 N3	Pro rata share of the hospital uncompensated care payment am	ount (see instructions)	0	239. 852	35. 03
	Total uncompensated care (sum of columns 1 and 2 on line 35.		239, 852	237, 032	36. 00
00.00	Additional payment for high percentage of ESRD beneficiary d				00.00
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40.00
	652, 682, 683, 684 and 685 (see instructions)				
			Before 1/1	On/After 1/1	
			1. 00	1. 01	
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0	0	41. 00
41 01	instructions)	DDC- /F2 /02 /02 /04			41 01
41. 01	Total ESRD Medicare covered and paid discharges excluding MS an 685. (see instructions)	-DRGS 652, 682, 683, 684	0	0	41. 01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42. 00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6				43. 00
	instructions)	,,			
44.00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.00
	days)				
45. 00	Average weekly cost for dialysis treatments (see instruction		0.00	0.00	45.00
	Total additional payment (line 45 times line 44 times line 4	1.01)	1 044 054		46. 00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	emall rural bosnitals	1, 944, 956		47. 00 48. 00
40.00	only. (see instructions)	sillari rurar nospitars			46.00
	y. (See That detroils)			Amount	
				1. 00	
49.00	Total payment for inpatient operating costs (see instruction			1, 944, 956	49.00
50. 00	Payment for inpatient program capital (from Wkst. L, Pt. I a			131, 478	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt			0	51.00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, I	The 49 see Instructions).		0	52. 00 53. 00
54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0	54. 00
54. 01	Islet isolation add-on payment			0	54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	55. 00
56. 00	Cost of physicians' services in a teaching hospital (see int			o	56. 00
57.00	Routine service other pass through costs (from Wkst. D, Pt.	III, column 9, lines 30 t	hrough 35).	0	57.00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	58. 00
59. 00	Total (sum of amounts on lines 49 through 58)			2, 076, 434	
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minu	s line 60)		2, 076, 434	
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			295, 652	62. 00 63. 00
64. 00	Allowable bad debts (see instructions)			40, 831	64. 00
65. 00	Adjusted reimbursable bad debts (see instructions)			26, 540	65. 00
	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		17, 065	66. 00
66.00		,		1, 807, 322	67. 00
	Subtotal (line 61 plus line 65 minus lines 62 and 63)				(0.00
66. 00 67. 00 68. 00		applicable to MS-DRGs (s	ee instructions)	0	68. 00
66. 00 67. 00 68. 00 69. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96)			0	69. 00
66. 00 67. 00 68. 00 69. 00 70. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. (For SCH see instruction	s)	0 0	69. 00 70. 00
66. 00 67. 00 68. 00 69. 00 70. 00 70. 50	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	. (For SCH see instruction tration) adjustment (see	s)	0 0 0	69. 00 70. 00 70. 50
66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration	. (For SCH see instruction tration) adjustment (see	s)	0 0 0	69. 00 70. 00 70. 50 70. 87
66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	.(For SCH see instruction tration) adjustment (see	s)	0 0 0 0	69. 00 70. 00 70. 50 70. 87 70. 88
66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	.(For SCH see instruction tration) adjustment (see	s)	0 0 0 0 0	69. 00 70. 00 70. 50 70. 87 70. 88 70. 89
66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	.(For SCH see instruction tration) adjustment (see	s)	0 0 0 0	69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90
66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	.(For SCH see instruction tration) adjustment (see	s)	0 0 0 0 0 0	69. 00 70. 00 70. 50 70. 87 70. 88 70. 89
66. 00 67. 00 68. 00 69. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	.(For SCH see instruction tration) adjustment (see	s)	0 0 0 0 0 0	69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91
66. 00 67. 00 68. 00 69. 00 70. 00 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92 70. 93 70. 94	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)	.(For SCH see instruction tration) adjustment (see	s)	0 0 0 0 0 0 0 0 12, 775	69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92

Health Financial Systems	FAYETTE REGIONAL HE	ALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der Co		Peri od: From 10/01/2016 To 09/30/2017	Worksheet E	pared:
		Title	XVIII	Hospi tal	PPS	
				(уууу)	Amount	
				0	1.00	
70.96 Low volume adjustment for federal the corresponding federal year for		column 0		0	0	70. 96
70. 97 Low volume adjustment for federal the corresponding federal year for	fiscal year (yyyy) (Enter ir			2017	385, 253	70. 97
70. 98 Low Volume Payment-3		ŕ			0	70. 98
70.99 HAC adjustment amount (see instruc-	tions)				0	70. 99
71.00 Amount due provider (line 67 minus	lines 68 plus/minus lines 6	9 & 70)			2, 205, 350	71.00
71.01 Sequestration adjustment (see insti	ructions)				44, 107	71. 01
71.02 Demonstration payment adjustment a	mount after sequestration				0	71. 02
72.00 Interim payments					1, 993, 097	72.00
73.00 Tentative settlement (for contracto	or use only)				0	73.00
74.00 Balance due provider/program (line 73)	71 minus lines 71.01, 71.02	, 72, and			168, 146	74. 00
75.00 Protested amounts (nonallowable co- CMS Pub. 15-2, chapter 1, §115.2	, ,	ce with			273, 700	75. 00
TO BE COMPLETED BY CONTRACTOR (line						
90.00 Operating outlier amount from Wkst.		ructi ons)			0	
91.00 Capital outlier from Wkst. L, Pt.					0	
92.00 Operating outlier reconciliation ad					0	92. 00
93.00 Capital outlier reconciliation adju					0	
94.00 The rate used to calculate the time		ctions)			0.00	
95.00 Time value of money for operating		>			0	
96.00 Time value of money for capital rel	lated expenses (see Instruct	ions)		Dr. or to 10/1	0 /After 10/1	96. 00
				Prior to 10/1 1.00	0n/After 10/1 2.00	
HSP Bonus Payment Amount				1.00	2.00	
100.00 HSP bonus amount (see instructions)	)				0	100. 00
HVBP Adjustment for HSP Bonus Payme	,					100.00
101.00 HVBP adjustment factor (see instruc					0.000000000	101 00
102.00 HVBP adjustment amount for HSP bond		3				102.00
HRR Adjustment for HSP Bonus Paymer						1
103.00 HRR adjustment factor (see instruc-					0.0000	103.00
104.00 HRR adjustment amount for HSP bonus						104.00
Rural Community Hospital Demonstrat		ation) Adju	stment			1
200.00 Is this the first year of the curre Century Cures Act? Enter "Y" for year		iod under t	he 21st			200. 00
Cost Reimbursement						
201.00 Medicare inpatient service costs (	from Wkst. D-1, Pt. II, lin∈	49)				201. 00
202.00 Medicare discharges (see instruction	ons)					202. 00
203.00 Case-mix adjustment factor (see ins	structions)					203. 00
Computation of Demonstration Target	t Amount Limitation (N/A in	first year	of the curre	nt 5-year demonst	ration	
peri od)						1
204.00 Medicare target amount						204. 00
205 OULCase_miv adjusted target amount ()	ino unu timos lino una)			1		DOE OO

205. 00 206. 00

207. 00

208. 00

209. 00

210. 00 211. 00

212. 00 213. 00 218. 00

205.00 Case-mix adjusted target amount (line 203 times line 204)

209.00 Adjustment to Medicare IPPS payments (see instructions)

(line 212 minus line 213) (see instructions)

213.00 Low-volume adjustment (see instructions)

210.00 Reserved for future use

206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement

207.00 Program reimbursement under the §410A Demonstration (see instructions)

208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)

Comparision of PPS versus Cost Reimbursement
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

211.00 Total adjustment to Medicare IPPS payments (line 209 plus line 210) (see instructions)

218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0064

1.00   BRS amounts other than outlier   1.00   0   0   0   0   0   0   0   0   0					T: +1 -	WILL I	11: 4-1	2/26/2018 10:	28 am
1.00   BBG amounts often then outline   0   0   0   0   0   0   0   0   0			W/S F Part A	Amounts (from			Hospi tal Peri od	PPS Total (Col. 2	
1.00   DAG amounts other than outlier   1.00   0   0   0   0   0   0   0   0   0									
Designation	1.00	Inno.			2. 00		4. 00		1 00
1.01   1.02   1.03   1.03   1.04   1.04   1.05	1.00		1.00	0	0	0	0	0	1.00
1.02   DRC unsourins other than outlier   1.02   1.630.424   0   1.630.424   1.630.424   1.02   1.630.424   1.02   1.630.424   1.02   1.630.424   1.02   1.03   1.03   1.03   1.03   1.03   1.03   1.03   1.03   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1	1. 01	DRG amounts other than outlier payments for discharges	1. 01	0	O	0		0	1. 01
Department of the Model   BPCI   Security in prime to   Se	1. 02	DRG amounts other than outlier payments for discharges	1. 02	1, 630, 424	0		1, 630, 424	1, 630, 424	1. 02
1,04	1.03	operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1. 03
2.00	1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	O		0	0	1. 04
2.01   Outlier payments for	2. 00	Outlier payments for	2. 00	25, 767	0	0	25, 767	25, 767	2. 00
3.00   Operating outlier   2.01   O   O   O   O   O   O   O   O   O	2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
A compared care simulated   3.00   0   0   0   0   0   0   0   4.00	3.00	Operating outlier	2. 01	0	0	0	0	0	3. 00
Indirect Medical Education Adjustment   21.00   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	4. 00	Managed care simulated	3. 00	0	0	0	0	0	4. 00
A, I In e 21 (see instructions) 6.00   IME payment adjustment (see   22.00   0   0   0   0   0   0   0   0   0		Indirect Medical Education Adju							
6.00   IME payment adjustment (see   22.00   0   0   0   0   0   0   0   0   0	5.00	The state of the s	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
Managed care (see instructions)	6. 00	IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
Instructions   Indirect Medical Education Adjustment For the Add-on For Section 422 of the MMA	6. 01	IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
1.00   IME payment adjustment factor   27.00   0.0000000   0.000000   0.00000000		instructions)	istment for the	Add on for Soc	rtion 422 of t	ho MMA			
1	7. 00	IME payment adjustment factor					0. 000000		7. 00
8.01   ME payment adjustment add on for managed care (see Instructions)   Total IME payment (sum of Instructions)   Total IME payment for managed care (sum of Instructions)   Total IME payment for managed care (sum of Instructions)   Total IME payment for managed care (sum of Instructions)   Total IME payment for managed care (sum of Instructions)   Total IME payment for managed care (sum of Instructions)   Total IME payment (see instructions)   Total IME payment (see instructions)   Total Imensions (s	8. 00	IME adjustment (see	28. 00	0	0	0	0	0	8. 00
9.00 Total IME payment (sum of lines 6 and 8) 9.01 Total IME payment for managed care (sum of lines 6 and 8) 9.01 Total IME payment for managed care (sum of lines 6 and 8) 9.01 Total IME payment for managed care (sum of lines 6 and 8)  10.00 Al lowable disproportionate Share Adjustment 10.00 Al lowable disproportionate share adjustment (sum of lines 6 and 8) 11.00 Disproportionate share adjustment (sum of lines 6 and 8) 11.00 Disproportionate share adjustment (sum of lines 8 and 9) 11.01 Uncompensated care payments 36.00 48,913 0 0 48,913 48,913 11.00 11.01 Uncompensated care payments 36.00 239,852 0 0 239,852 239,852 11.01 11.02 Total ESRD additional payment for high percentage of ESRD beneficiary discharges 11.00 Total ESRD additional payment 46.00 0 0 0 0 0 0 0 0 12.00 13.00 Subtotal (see instructions) 47.00 1,944,956 0 0 0 1,944,956 13.00 14.00 14.00 Hospital specific payments 48.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8. 01	IME payment adjustment add on for managed care (see	28. 01	О	O	0	0	0	8. 01
9.01 Total IME payment for managed 29.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00	Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
Disproportionate Share Adjustment   33.00   0.1200   0.	9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	0	0	0	9. 01
Share percentage (see   instructions)   11.00   10   10   10   10   10   10		Di sproporti onate Share Adjustme							
11.00   Disproportionate share   34.00   48,913   0   0   48,913   11.00   adjustment (see instructions)   11.01   11.00   1	10. 00		33. 00	0. 1200	0. 1200	0. 1200	0. 1200		10. 00
11. 01   Uncompensated care payments   36. 00   239, 852   0   0   239, 852   239, 852   11. 01	11. 00	instructions)	34. 00	48, 913	0	0	48, 913	48, 913	11. 00
12.00   Total ESRD additional payment (see instructions)   46.00   0   0   0   0   0   12.00   13.00   Subtotal (see instructions)   47.00   1,944,956   0   0   1,944,956   1,944,956   13.00   14.00   Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)   15.00   Total payment for inpatient operating costs (see instructions)   16.00   Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)   17.00   Special add-on payments for new technologies   17.01   Net organ aquisition cost   17.02   Credits received from   68.00   0   0   0   0   0   0   0   17.00    13.00   0   0   0   0   0   0   0   0   0	11. 01	Uncompensated care payments				0	239, 852	239, 852	11. 01
(see instructions) 3ubtotal (see instructions) 47.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)  15.00 Total payment for inpatient operating costs (see instructions)  16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)  17.00 Special add-on payments for new technologies  17.01 Net organ aquisition cost 17.02 Credits received from 68.00  0  1,944,956 0 0 0 1,944,956 0 0 0 1,944,956 1,944,95	10.00							^	12.00
14. 00       Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)       48. 00       0       0       0       0       0       14. 00         15. 00       Total payment for inpatient operating costs (see instructions)       49. 00       1,944,956       0       0       1,944,956       15. 00         16. 00       Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)       50. 00       131,478       0       0       131,478       131,478       16. 00         17. 00       Special add-on payments for new technologies       54. 00       0       0       0       0       0       0       0       0       17. 01         17. 01       Net organ aquisition cost       68. 00       0 <td></td> <td>(see instructions)</td> <td></td> <td></td> <td>O</td> <td>0</td> <td></td> <td></td> <td></td>		(see instructions)			O	0			
15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 17.02 Credits received from manufacturers for replaced 17.02 Total payment for inpatient program 50.00 1,944,956 0 0 0 1,944,956 1,944,956 15.00 0 0 131,478 16.00 0 0 0 131,478 131,478 16.00 0 0 0 0 0 0 17.00 0 0 17.00 0 0 0 17.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Hospital specific payments (completed by SCH and MDH,		1, 944, 956 0	0	0	1, 944, 956 0	1, 944, 956 0	13. 00 14. 00
16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)  17.00 Special add-on payments for new technologies  17.01 Net organ aquisition cost  17.02 Credits received from manufacturers for replaced  50.00 131,478 0 0 0 131,478 16.00 0 0 0 171.00 0 0 171.00 0 0 171.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00	Total payment for inpatient operating costs (see	49. 00	1, 944, 956	0	0	1, 944, 956	1, 944, 956	15. 00
17. 00 Special add-on payments for new technologies     54. 00     0     0     0     0     0     17. 00       17. 01 Net organ aquisition cost     17. 01 Credits received from manufacturers for replaced     68. 00     0 <td>16. 00</td> <td>Payment for inpatient program capital (from Wkst. L, Pt. I,</td> <td>50. 00</td> <td>131, 478</td> <td>0</td> <td>0</td> <td>131, 478</td> <td>131, 478</td> <td>16. 00</td>	16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	131, 478	0	0	131, 478	131, 478	16. 00
17. 01       Net organ aquisition cost       17. 01         17. 02       Credits received from manufacturers for replaced       68. 00       0       0       0       0       0       0       0       17. 02	17. 00	Special add-on payments for	54. 00	О	0	0	0	0	17. 00
		Net organ aquisition cost Credits received from manufacturers for replaced		O	0	0	О	0	17. 01 17. 02

Hear th	Financiai Systems	F.F	AYETTE REGIONAL	HEALTH SYSTEM		in Lie	U OT FORM CMS-2	2552-10
LOW VO	DLUME CALCULATION EXHIBIT 4			Provider CO	F	eriod: rom 10/01/2016 o 09/30/2017	Worksheet E Part A Exhibi Date/Time Pre 2/26/2018 10:	pared:
				Title	XVIII	Hospi tal	PPS	
	·	W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	C	0	0	18. 00
19.00	SUBTOTAL			0	C	2, 076, 434	2, 076, 434	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	129, 530	0	C	129, 530	129, 530	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	C	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	1, 948	0	C	1, 948	1, 948	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	C	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.0000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	C	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0. 0000	0. 0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0	C	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	131, 478	0	C	131, 478	131, 478	26. 00
		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				0.000000	0. 185536		27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			C		0	28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 97				385, 253	385, 253	29. 00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Heal th Financial Systems

FAYETTE REGIONAL HEALTH SYSTEM

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

From 10/01/2016
To 09/30/2017

Title XVIII

Hospital

PPS

Wikst. E, Pt. Amt. from Period to A, line
Wikst. E, Pt. A)

O 1.00

DRG amounts other than outlier payments

PAYETTE REGIONAL HEALTH SYSTEM

In Lieu of Form CMS-2552-10

Worksheet E
Part A Exhibit 5
Date/Time Prepared: 2/26/2018 10: 28 am
PPS

Total (cols. 2 and 3)

1.00

DRG amounts other than outlier payments

1.00

			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt.	Amt. from	Period to	Period on	Total (cols. 2	
		A, line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
		0	A) 1.00	2.00	3. 00	4. 00	
1.00	DRG amounts other than outlier payments	1. 00	1.00	2.00	3.00	4.00	1. 00
1. 01	DRG amounts other than outlier payments for	1. 01	ol	0		0	1. 01
	discharges occurring prior to October 1			-			
1.02	DRG amounts other than outlier payments for	1. 02	1, 630, 424		1, 630, 424	1, 630, 424	1. 02
	discharges occurring on or after October 1		_			_	
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	0		0	1. 03
	1						
1. 04	DRG for Federal specific operating payment	1. 04	ol		0	0	1. 04
	for Model 4 BPCI occurring on or after						
	October 1						
2.00	Outlier payments for discharges (see	2. 00	25, 767	0	25, 767	25, 767	2. 00
2. 01	instructions)	2. 02		0	0	0	2. 01
2.01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	U	0	0	2.01
3.00	Operating outlier reconciliation	2. 01	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	Ö	0	0		4. 00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21	21. 00	0. 000000	0. 000000	0. 000000		5. 00
	(see instructions)	00.00					, 00
6.00	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	0	0	0	0	6. 00 6. 01
6. 01	instructions)	22.01	١	U	Ü	0	6.01
	Indirect Medical Education Adjustment for the	Add-on for Se	ction 422 of th	ne MMA			
7.00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7. 00
	instructions)						
8.00	IME adjustment (see instructions)	28. 00	0	0	0	_	8. 00
8. 01	IME payment adjustment add on for managed	28. 01	0	0	0	0	8. 01
9. 00	care (see instructions) Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of	29. 01		0	0	0	9. 01
7. 0.	lines 6.01 and 8.01)	27.0.		ŭ	· ·		,, , ,
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage	33.00	0. 1200	0. 1200	0. 1200		10. 00
44.00	(see instructions)	0.4.00	40.040		40.040	40.040	44.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	48, 913	0	48, 913	48, 913	11. 00
11. 01	Uncompensated care payments	36. 00	239, 852	0	239, 852	239, 852	11. 01
	Additional payment for high percentage of ESR						
12.00	Total ESRD additional payment (see	46. 00	0	0	0	0	12. 00
	instructions)						
13.00	Subtotal (see instructions)	47.00	1, 944, 956	0	1, 944, 956		
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48. 00	٥	U	0	0	14. 00
	instructions)						
15. 00	Total payment for inpatient operating costs	49. 00	1, 944, 956	0	1, 944, 956	1, 944, 956	15. 00
	(see instructions)						
16. 00	Payment for inpatient program capital (from	50. 00	131, 478	0	131, 478	131, 478	16. 00
17.00	Wkst. L, Pt. I, if applicable)	E4 00		0	0		17.00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	0	0	0	0	17. 00 17. 01
17. 01	Credits received from manufacturers for	68. 00	o	0	0	0	17. 01
02	replaced devices for applicable MS-DRGs	33.00		J	O		02
18. 00	Capital outlier reconciliation adjustment	93.00	О	0	0	0	18. 00
40	amount (see instructions)						40
19. 00	SUBTOTAL			0	2, 076, 434	2, 076, 434	19.00

Health Financial Systems	FAYETTE	REGI ONAL	HEALTH SYSTEM		In Lieu	u of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION (HAC)	REDUCTION CALCULATION E	EXHIBIT 5	Provi der CC	CN: 15-0064	From 10/01/2016	Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/26/2018 10:28 am
			Ti +Lo	VVIII	∐osni tal	DDC

THE HOLD CONDITION (THO) RESIDENCE CALLED TO	TON EXILIBITION	Trovider ex		From 10/01/2016 To 09/30/2017		pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	129, 530	(	129, 530	129, 530	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0	(	0	0	20. 01
21.00 Capital DRG outlier payments	2.00	1, 948	(	1, 948	1, 948	21. 00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0	(	0	0	21. 01
22.00 Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.0000		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0	(	0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0.0000		24. 00
25.00 Disproportionate share adjustment (see instructions)	11. 00	0	(	0	0	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	131, 478	(	131, 478	131, 478	26. 00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0			0	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	385, 253		385, 253	385, 253	29. 00
30.00 HVBP payment adjustment (see instructions)	70. 93	12, 775		12, 775	12, 775	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	(	0	0	30. 01
31.00 HRR adjustment (see instructions)	70. 94	0	(	0	0	31. 00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	(	0	0	31. 01
					(Amt. to Wkst. E, Pt. A)	
	0	1. 00	2.00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99		(	0	0	
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0064	Peri od: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/26/2018 10:28 am

		10 09/30/2017	2/26/2018 10:	
		Title XVIII Hospital	PPS	20 4111
		THE ATTENDED TO	1	
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		1.00	
1.00	Medical and other services (see instructions)		9, 519	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	tions)	7, 195, 464	
3. 00	OPPS payments		4, 750, 042	
4.00	Outlier payment (see instructions)		11, 097	4. 00
4. 01	Outlier reconciliation amount (see instructions)		0	
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)	0.000	5. 00
6.00	Line 2 times line 5		0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7. 00
8.00	Transitional corridor payment (see instructions)		0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200	0	9. 00
10.00	Organ acqui si ti ons		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		9, 519	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonabl e charges			
12.00	Ancillary service charges		28, 540	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		28, 540	14. 00
	Customary charges			
15.00	Aggregate amount actually collected from patients liable for patients	payment for services on a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for	payment for services on a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(	e)		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17. 00
18. 00	Total customary charges (see instructions)		28, 540	
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds line 11) (see	19, 021	19. 00
	instructions)			
20. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds line 18) (see	0	20. 00
	instructions)		0.540	
21. 00	Lesser of cost or charges (line 11 minus line 20) (see instruc	ctions)	1	21. 00
22. 00	Interns and residents (see instructions)		0	
23. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		4, 761, 139	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			25 00
25. 00	Deductibles and coinsurance (for CAH, see instructions)	c CAU coo instructions)	996, 533	
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for		3, 774, 125	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) prinstructions)	orus the sum or rithes 22 and 23] (see	3, 774, 123	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ne 50)	0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	110 30)	0	
30.00	Subtotal (sum of lines 27 through 29)		3, 774, 125	
31. 00	Primary payer payments		0	1
32. 00	Subtotal (line 30 minus line 31)		3, 774, 125	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33. 00
34.00	Allowable bad debts (see instructions)		181, 894	
35.00	Adjusted reimbursable bad debts (see instructions)		118, 231	
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	164, 148	
37.00	Subtotal (see instructions)		3, 892, 356	37. 00
38.00	MSP-LCC reconciliation amount from PS&R		0	38. 00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)	0	39. 50
39. 97	Demonstration payment adjustment amount before sequestration		0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instructions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		0	39. 99
40.00	Subtotal (see instructions)		3, 892, 356	40.00
40. 01	Sequestration adjustment (see instructions)	77, 847	40. 01	
40. 02				
41.00				41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-14, 710	43.00
44.00				44. 00
	§115. 2	· · · · · · · · · · · · · · · · · · ·		
	TO BE COMPLETED BY CONTRACTOR			
90. 00	Original outlier amount (see instructions)		0	
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91. 00
92. 00	The rate used to calculate the Time Value of Money		0.00	
93. 00	Time Value of Money (see instructions)		0	
94.00	Total (sum of lines 91 and 93)		0	94. 00

| Peri od: | Worksheet E-1 | From 10/01/2016 | Part | To 09/30/2017 | Date/Time Prepared: | 2/26/2018 10: 28 am Health Financial Systems FAYETT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0064

					2/26/2018 10: 2	28 am
			XVIII	Hospi tal	PPS	
		I npati er	it Part A	Pai	^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		1, 993, 09		3, 698, 269	1. 00
2.00	Interim payments payable on individual bills, either			O	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
0.00	write "NONE" or enter a zero					0.00
3. 00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		1	0 09/30/2017	130, 950	3. 01
3. 02	THE STATE OF THE TREET OF THE STATE OF THE S			0	0	3. 02
3. 03				0	0	3. 03
3. 04				o o	0	3. 04
3. 05				o	o	3. 05
	Provider to Program			-	_	
3.50	ADJUSTMENTS TO PROGRAM			O	0	3. 50
3.51				0	0	3. 51
3.52				0	0	3. 52
3.53				O	0	3. 53
3.54				O	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			O	130, 950	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 993, 09	7	3, 829, 219	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after	I	I			5. 00
5.00	desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				o	o	5. 02
5. 03				o o	0	5. 03
	Provider to Program	•				
5.50	TENTATI VE TO PROGRAM		(	0	0	5. 50
5.51				O	0	5. 51
5.52				O	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			O	0	5. 99
	5. 50-5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		168, 14	6	0	6. 01
6. 02	SETTLEMENT TO PROVIDER		100, 141		14, 710	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 161, 24	3	3, 814, 509	7. 00
7.00	Tiotal medicale program frability (see instructions)		2, 101, 24.	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
			)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	·	•		•		

Health Financial Systems		FAYETTE REGIONAL I	HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS	FOR SERVICES	RENDERED	Provider CCN: 15-0064	Peri od:	Worksheet E-1

| Component CCN: 15-S064 | To 09/30/2017 | Date/Time Prepared: 2/26/2018 10: 28 am | Title XVIII | Subprovider - PPS

		Title	XVIII	Subprovi der - I PF	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		1, 384, 932 C		0	1. 00 2. 00
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					3. 00
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	I	C		0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER					3. 01
3. 03			Ö		0	3. 02
3. 04			ď			3. 04
3. 05			Ö		l ol	3. 05
	Provider to Program			<b>"</b>		
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3.51			C	)	0	3. 51
3.52			C	)	0	3. 52
3.53			C		0	3. 53
3.54			C		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		С		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 384, 932		0	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider	ı	_	1	_	
5. 01	TENTATI VE TO PROVI DER		O		0	5. 01
5. 02 5. 03			C   C		0	5. 02 5. 03
5.03	Provider to Program				0	5.03
5. 50	TENTATI VE TO PROGRAM		C	1	0	5. 50
5. 51	TENTAL TO TROOM III		ď			5. 51
5. 52			Ö		l ol	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C		0	5. 99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		23, 758	1	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		C		0	6. 02
7.00	Total Medicare program liability (see instructions)		1, 408, 690		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
0.00	Name of Combination	(	)	1. 00	2. 00	0.00
8. 00	Name of Contractor	I		1	1	8. 00

ANALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	'	CCN: 15-U064	Period: From 10/01/2016 To 09/30/2017	Date/Time Pre 2/26/2018 10:	pared:
				Swing Beds - SNF		
		Inpatien	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider	1.00		0	4.00	1.00
2. 00	Interim payments payable on individual bills, either		1	0	0	
2.00	submitted or to be submitted to the contractor for				ľ	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					1
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provider to Program					1
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	3. 51
3.52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)			0	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	1	1		Г	
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 01	Program to Provider TENTATIVE TO PROVIDER	I	T			F 01
5. 01 5. 02	TENTATIVE TO PROVIDER			0	0	
5. 02		•	1	0		
5.05	Provider to Program			U	0	5.03
5. 50	TENTATI VE TO PROGRAM			ol	0	5. 50
5. 50	TENTATIVE TO PROGRAW		1	0		
5. 51			1	0	0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
5. 77	5. 50-5. 98)			O O		3. 77
6. 00	Determined net settlement amount (balance due) based on					6, 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		1	o	o o	
7. 00	Total Medicare program liability (see instructions)		1	0	0	
00			1	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	0	1.00	2.00	
8. 00	Name of Contractor					8. 00

8. 00

8.00 Name of Contractor

Heal th	Financial Systems FAYETTE REGIONAL H	EALTH SYSTEM	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0064	Peri od: From 10/01/2016	Worksheet E-1 Part II	
			To 09/30/2017	Date/Time Pre 2/26/2018 10:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00					
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	Polones due provider (line 0 (er line 10) minus line 20 and l	ing 21) (and implementation	20		22 00

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

30. 00 31. 00 32. 00

Health Financial Systems	FAYETTE REGIONAL HE	EALTH SYSTEM	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-0064	Peri od: From 10/01/2016	Worksheet E-2
		Component CCN: 15-U064		

		Component Con. 13-0004	10 07/30/2017	2/26/2018 10:	
		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		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 Par				3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see in				
4. 00	Per diem cost for interns and residents not in approved teach	ing program (see		0. 00	4. 00
	instructions)				
5.00	Program days		0	0	
6.00	Interns and residents not in approved teaching program (see in	•	0	0	
7.00	Utilization review - physician compensation - SNF optional me	thod only	0	_	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	0	
9.00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)	aabla ta mbuaiaian	0	0	
11. 00	Deductibles billed to program patients (exclude amounts appliance) professional services)	cable 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 records)	) (exclude coinsurance	0	0	13.00
13.00	for physician professional services)	(exclude collisulance		0	13.00
14. 00	80% of Part B costs (line 12 x 80%)			0	14. 00
	Subtotal (enter the lesser of line 12 minus line 13, or line	14)	0	0	1
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	0	Ö	
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)	0	0	1
16. 55	Rural community hospital demonstration project (§410A Demonstr	•	0		16. 55
	adjustment (see instructions)	,			
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17.00	Allowable bad debts (see instructions)		0	0	17. 00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)	0	0	18. 00
19.00	Total (see instructions)		0	0	19. 00
	Sequestration adjustment (see instructions)		0	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
20.00	Interim payments		0	0	20.00
21. 00	Tentative settlement (for contractor use only)		0	0	
22. 00		•	0	0	
23. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration per	riod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				-
201 00	Cost Reimbursement  Medicare swing-bed SNF inpatient routine service costs (from N	Wkst D 1 Dt II line			201. 00
201.00	66 (title XVIII hospital))	WKSt. D-1, Pt. 11, Title			201.00
202 00	Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst D_3 col 3 lin			202. 00
202.00	200 (title XVIII swing-bed SNF))	II WK31. D-3, COI. 3, III			202.00
203 00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204. 00
201.00	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-vear demonst	ration	201.00
	peri od)		o jour domono.		
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	imes line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				1
207.00	Program reimbursement under the §410A Demonstration (see instr	ructions)			207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	· ·	1		208. 00
	and 3)				
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209. 00
210.00	Reserved for future use				210. 00
	Comparision of PPS versus Cost Reimbursement				
215. 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215. 00
	instructions)				

Health Financial Systems	FAYETTE REGIONAL H	EALTH SYSTEM	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-0064	Peri od: From 10/01/2016	Worksheet E-2
		Component CCN: 15-U064		

		, , , , , , , , , , , , , , , , , , , ,		2/26/2018 10: 28
		Title XIX	Swing Beds - SNF	PPS
			Part A	Part B
	COMPLITATION OF NET COST OF COVERED CERVILORS		1.00	2.00
	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		O	
	Inpatient routine services - swing bed-NF (see instructions)		0	
4	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	t A and sum of Wkst D	0	
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins			
	Per diem cost for interns and residents not in approved teachi		0.00	
	instructions)	ng program (see	0.00	
- 1	Program days		0	
1	Interns and residents not in approved teaching program (see in	nstructions)	0	
	Utilization review - physician compensation - SNF optional met		0	
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	
00 1	Primary payer payments (see instructions)		0	
0. 00	Subtotal (line 8 minus line 9)		0	1
. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	1
	professi onal servi ces)			
- 1	Subtotal (line 10 minus line 11)		0	1
	Coinsurance billed to program patients (from provider records)	(exclude coinsurance	0	1
	for physician professional services)			
	80% of Part B costs (line 12 x 80%)	143	0	1
	Subtotal (enter the lesser of line 12 minus line 13, or line 1	14)	0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-)	0	1
	Pioneer ACO demonstration payment adjustment (see instructions Rural community hospital demonstration project (§410A Demonstr			'1
	adjustment (see instructions)	ation) payment		'
	Demonstration payment adjustment amount before sequestration		0	1
- 1	Allowable bad debts (see instructions)			1
	Adjusted reimbursable bad debts (see instructions)		0	1
- 1	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	1
	Total (see instructions)	•	0	1
0. 01	Sequestration adjustment (see instructions)		0	1
0. 02   1	Demonstration payment adjustment amount after sequestration)		0	1
0.00	Interim payments		0	2
. 00	Tentative settlement (for contractor use only)		0	2
	Balance due provider/program (line 19 minus lines 19.01, 20, a	*	0	2
	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2,	0	2
	chapter 1, §115.2			
	Rural Community Hospital Demonstration Project (§410A Demonstr			0.5
	Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	rod under the 21st		20
	Cost Reimbursement			
	Medicare swing-bed SNF inpatient routine service costs (from W	Wkst D-1 Pt II line		20
	66 (title XVIII hospital))			[
	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3, col. 3, line		20
]:	200 (title XVIII swing-bed SNF))			
3.00	Total (sum of lines 201 and 202)			20
	Medicare swing-bed SNF discharges (see instructions)			20
C	Computation of Demonstration Target Amount Limitation (N/A in	first year of the current	t 5-year demonstr	ration
	peri od)			
	Medicare swing-bed SNF target amount	11 004		20
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti			20
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs			20
	Program reimbursement under the §410A Demonstration (see instr	•		20
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	z, cor. I, sum of fines i		20
- 1	and 3) Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)	1	20
	Reserved for future use	2013)		21
	Comparision of PPS versus Cost Reimbursement			
	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see		21
	,		1	-·

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: From 10/01/2016	Worksheet E-3
	Component CCN: 15-S064		
	Title XVIII	Subprovi der – I PF	PPS
		IPF	

	IP	F		
	DART LL MEDICARE DART A CERMINES ARE		1. 00	
1 00	PART II - MEDICARE PART A SERVICES - IPF PPS		1 522 220	1 00
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		1, 522, 338	1. 00 2. 00
2. 00 3. 00	Net IPF PPS Outlier Payments Net IPF PPS ECT Payments		30, 979 0	3. 00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before Nove	ombor	0.00	4. 00
4.00	15, 2004. (see instructions)	HIDEI	0.00	4.00
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displace	ed by	0.00	4. 01
7.01	program or hospital closure, that would not be counted without a temporary cap adjustment under	, ,	0.00	7.01
	CFR \$412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	'-		
5.00	New Teaching program adjustment. (see instructions)		0.00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a	a "new	0.00	6. 00
	teaching program" (see instuctions)			
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a	a "new	0.00	7.00
	teaching program" (see instuctions)			
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		6. 142466	9. 00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.		0.000000	10.00
11. 00	Teaching Adjustment (line 1 multiplied by line 10).		0	11. 00
12.00			1, 553, 317	12.00
13. 00			0	13.00
14. 00				14.00
15. 00	J		0	15.00
16. 00			1, 553, 317	
17. 00			0	17. 00
18. 00	, , , , , , , , , , , , , , , , , , , ,		1, 553, 317	18. 00
19. 00			100, 912	
20. 00			1, 452, 405	
21. 00			39, 207	
22. 00			1, 413, 198	
23. 00			37, 294	
24. 00	, ,		24, 241	
25. 00	J		21, 572	
26. 00			1, 437, 439	
27. 00	, , , , , , , , , , , , , , , , , , , ,		0	27. 00
28. 00 29. 00			0	28. 00 29. 00
	1 1.9		0	30.00
30. 00 30. 50			0	30. 50
30. 30	1.3		0	30. 30
31. 00	1		1, 437, 439	
31. 00	Sequestration adjustment (see instructions)		28, 749	
31. 02			20, 747	31. 02
32. 00			1, 384, 932	32. 00
33. 00			1, 304, 732	33. 00
34. 00	37		23, 758	34. 00
35. 00			20, 700	35. 00
00.00	§115. 2		Ü	00.00
	TO BE COMPLETED BY CONTRACTOR			
50. 00			30, 979	50. 00
51. 00			0	51. 00
52.00			0.00	52.00
53. 00	Time Value of Money (see instructions)		0	53.00
		'	. '	

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0064	Peri od:	Worksheet E-3
	Component CCN: 15-T064	From 10/01/2016 To 09/30/2017	
	Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I RF	PPS	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
1.00	Net Federal PPS Payment (see instructions)			0	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			0	3.00
4.00	Outlier Payments			0	4.00
5.00	Unweighted intern and resident FTE count in the most recent co	ost reporting period en	ding on or prior	0.00	5. 00
E 04	to November 15, 2004 (see instructions)			0.00	E 04
5. 01	Cap increases for the unweighted intern and resident FTE coun-			0. 00	5. 01
	program or hospital closure, that would not be counted withou CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	t a temporary cap adjusti	lient under 42		
6. 00	New Teaching program adjustment. (see instructions)			0.00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	7. 00
7.00	teaching program" (see instructions)	the new program growth po	cirod or a new	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0. 00	8. 00
	teaching program" (see instructions)	1 3 3 1			
9.00	Intern and resident count for IRF PPS medical education adjus-	tment (see instructions)		0. 00	9.00
10.00	Average Daily Census (see instructions)			0.000000	10.00
11. 00	Teaching Adjustment Factor (see instructions)			0.000000	11.00
12.00	Teaching Adjustment (see instructions)			0	12.00
13.00	Total PPS Payment (see instructions)			0	13.00
14. 00	Nursing and Allied Health Managed Care payments (see instruction	on)		0	14.00
15. 00	Organ acquisition (DO NOT USE THIS LINE)			_	15. 00
16. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	16.00
17. 00	Subtotal (see instructions)			0	17. 00
18.00	Primary payer payments			0	18.00
19. 00 20. 00	Subtotal (line 17 less line 18).			0	19. 00 20. 00
21. 00	Deductibles Subtotal (line 19 minus line 20)			0	21. 00
22. 00	Coi nsurance			0	22. 00
23. 00	Subtotal (line 21 minus line 22)			Ö	23. 00
24. 00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		0	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)	(666 11.61. 461. 61.6)		0	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		0	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	,		0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, Li	ne 49)		0	28.00
29. 00	Other pass through costs (see instructions)			0	29.00
30.00	Outlier payments reconciliation			0	30.00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	31. 50
31. 99	Demonstration payment adjustment amount before sequestration			0	31. 99
32. 00	Total amount payable to the provider (see instructions)			0	32.00
32. 01	Sequestration adjustment (see instructions)			0	32. 01
32. 02	Demonstration payment adjustment amount after sequestration			0	32. 02 33. 00
33. 00 34. 00	Interim payments Tentative settlement (for contractor use only)			0	34. 00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02	2 33 and 34)		0	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordan	•	chanter 1	0	36. 00
30. 00	§115. 2	ice with own rub. 13 2,	Snapter 1,	Ö	30. 00
	TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
52. 00	The rate used to calculate the Time Value of Money			0.00	
53. 00	Time Value of Money (see instructions)			0	53.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0064	Peri od: Worksheet E-3 From 10/01/2016 Part VII To 09/30/2017 Date/Time Prepared:

Interview   Content   Co				To 09/30/2017	Date/Time Pre 2/26/2018 10:	
Inpatt ent			Title XIX	Hospi tal		20 4
PART VII - CALCULATION OF RETIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						
COMPUTATION OF NET COST OF COVERED SERVICES   1.00   1.0						
COMPUTATION OF NET COST OF COVERED SERVICES   1.00   1.0		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	VICES FOR TITLES V OR XIX	SERVI CES		
Inpatient hospital/SNF/MF services						1
Medical and other services   0   2.00	1.00			279, 670		1.00
Organ acquisition (certified transplant centers only)				,	0	1
Subtotal (sum of lines 1, 2 and 3)				0		
Inpati ent primary payer payments   0   5.00   5.				279, 670	0	
0.00   Outpatient primary payer payments   0.6.00   0.7.00   0.				0		
279,670   0 7.00					0	
Reasonable Charges   8.00   8.00   8.00   8.00   9.00   Ancil lary service charges   533,798   0.9.00   10.00   0.00				279, 670	0	
8.00   Routine service charges   96,990   8.00   8.00   9.00   Ancil lary service charges   533,798   0.90   0.0		COMPUTATION OF LESSER OF COST OR CHARGES		<u> </u>		1
0,00   Ancillary service charges   533,798   0 9,00		Reasonable Charges				1
10.00   Organ acquisition charges, net of revenue   0   10.0	8.00	Routine service charges		96, 990		8. 00
11.00   Incentive from target amount computation   0   0   0   0   0   0   0   0   0	9.00	Ancillary service charges		533, 798	0	9. 00
12. 00   Total reasonable charges (sum of 'lines 8 through 11)   630,788   0   12. 00	10.00	Organ acquisition charges, net of revenue		0		10.00
CUSTOMARY CHARGES	11.00	Incentive from target amount computation		0		11. 00
13. 00   Amount actually collected from patients liable for payment for services on a charge   0   0   13. 00	12.00	Total reasonable charges (sum of lines 8 through 11)		630, 788	0	12. 00
basis   14.00   Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)   0.000000   0.000000   15.00   16.00		CUSTOMARY CHARGES				
14.00   Amounts that would have been realized from patients Liable for payment for services on a large basis had such payment been made in accordance with 42 CFR §413.13(e)   0.000000   0.000000   15.00   16.00   Ratio of line 13 to line 14 (not to exceed 1.000000)   0.000000   0.000000   0.000000   15.00   16.00	13.00		services on a charge	0	0	13. 00
a charge basis had such payment been made in accordance with 42 CFR \$413.13(e)  16. 00 Tatio of line 13 to line 14 (not to exceed 1.000000)  17. 00 Total customary charges (see instructions)  18. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 351.118  18. 00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)  19. 00 Interns and Residents (see instructions)  19. 00 Interns and Residents (see instructions)  19. 00 Interns and Residents (see instructions)  19. 00 Cost of physicians' services in a teaching hospital (see instructions)  10. 00 Cost of physicians' services in a teaching hospital (see instructions)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 ReposeECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.  10. 00 Utilier payments  10. 00 Utilier payments  10. 00 Quilier payments  10. 00 Qu						
15. 00	14. 00			0	0	14. 00
16.00   Total customary charges (see instructions)   17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   351, 118   0   17.00   17.			2 CFR §413.13(e)			
17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   11ne 4) (see Instructions)   0   18.00   16) (see instructions)   0   0   18.00   16) (see instructions)   0   0   19.00   16) (see instructions)   0   0   19.00   16) (see instructions)   0   0   19.00   160						
18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line   0   0   18.00   16) (see instructions)   0   0   19.00   10   10   10   10   10   10   10		, , ,	1611 47			
18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)   19.00   18.00   19.00   10.0	17.00		y if line 16 exceeds	351, 118	0	17.00
16) (see instructions)	10 00		u if line 4 evecede line		0	10.00
19.00   Interns and Residents (see instructions)   0   0   19.00   20.00   2	18.00		y II IIIne 4 exceeds IIIne	0	U	18.00
20.00   Cost of physicians' services in a teaching hospital (see instructions)   0   279,670   0   21.00	10 00			0	0	10 00
21.00			uctions)		-	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				٩	-	
22.00   Other than outlier payments   0   0   22.00	21.00					21.00
23.00   Outlier payments   0   0   23.00     24.00   Program capital payments   0   24.00     25.00   Capital exception payments (see instructions)   0   25.00     25.00   Routine and Ancillary service other pass through costs   0   0   26.00     27.00   Subtotal (sum of lines 22 through 26)   0   0   27.00     28.00   Customary charges (title V or XIX PPS covered services only)   0   0   28.00     29.00   Outlines   0   0   0   27.00     29.00   Outlines   0   0   0   27.00     29.00   Outlines   0   0   0   0     29.00   Outlines   0   0   0   0     29.00   Outlines   0   0   0     20.00   Outlines   0   0     20.00   Outlines   0   0   0     20.00   Outlines   0   0     20.00   Outlin	22 00		compressed for 113 provide		0	22 00
24. 00       Program capital payments       0       24. 00         25. 00       Capital exception payments (see instructions)       0       25. 00         26. 00       Routine and Ancillary service other pass through costs       0       0       26. 00         27. 00       Subtotal (sum of lines 22 through 26)       0       0       27. 00         28. 00       Customary charges (title V or XIX PPS covered services only)       0       0       28. 00         29. 00       Titles V or XIX (sum of lines 21 and 27)       279, 670       0       29. 00         COMPUTATION OF REIMBURSEMENT SETTLEMENT       279, 670       0       30. 00         31. 00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       279, 670       0       31. 00         32. 00       Deductibles       0       0       32. 00         33. 00       Coinsurance       0       0       32. 00         34. 00       Allowable bad debts (see instructions)       0       0       34. 00         35. 00       Utilization review       0       35. 00         36. 00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       279, 670       0       36. 00         37. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0<				-	-	
25.00 Capital exception payments (see instructions)  26.00 Routine and Ancillary service other pass through costs  27.00 Subtotal (sum of lines 22 through 26)  28.00 Customary charges (title V or XIX PPS covered services only)  28.00 Customary charges (title V or XIX PPS covered services only)  29.00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  279,670  30.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  32.00 Deductibles  33.00 Coinsurance  34.00 Allowable bad debts (see instructions)  35.00 Utilization review  36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  25.00  26.00  27.00  27.00  27.00  27.00  279,670  30.0					ŭ	
26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27) 29.00 Titles V or XIX (sum of lines 21 and 27) 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT  30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 30.00 Coinsurance 30.00 Allowable bad debts (see instructions) 31.00 Utilization review 32.00 Utilization review 33.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 30.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 0 27, 00 279, 670 0 26.00 279, 670 0 36.00 0 37.00 0 37.00 0 38.00 0 39.00 0 40.00 0 43.00				0		
27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 279, 670 0 29. 00  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 279, 670 0 31. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 279, 670 0 31. 00 32. 00 Deductibles 0 0 0 32. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 279, 670 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 279, 670 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 279, 670 0 40. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 279, 670 0 40. 00 41. 00 Interim payments (line 40 minus line 41) -75, 797 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00	26, 00			0	0	26, 00
28.00   Customary charges (title V or XIX PPS covered services only)   0   28.00   29.00   Titles V or XIX (sum of lines 21 and 27)   279,670   0   29.00   29.00   279,670   0   30.00   29.00   279,670   0   31.00   30.00   279,670   0   31.00   31.00   32.00   279,670   0   31.00   32.00   279,670   0   31.00   32.00   279,670   0   32.00   33.00   279,670   0   33.00   279,670   0   33.00   279,670   0   33.00   279,670   0   34.00   35.00   279,670   0   35.00   279,670   0   35.00   279,670   0   35.00   279,670   0   35.00   279,670   0   35.00   279,670   0   36.00   279,670   0   36.00   279,670   0   37.00   38.00   39.00   279,670   0   38.00   39.00   279,670   0   38.00   39.00   279,670   0   38.00   39.00   279,670   0   39.00   279,670   0   39.00   279,670   0   39.00   39.00   279,670   0   39.00   35.0				0	0	27. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT   30.00   Excess of reasonable cost (from line 18)   0   0   30.00   31.00   Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   279,670   0   31.00   32.00   32.00   33.00   Coinsurance   0   0   0   32.00   33.00   Allowable bad debts (see instructions)   0   0   0   34.00   35.00   Utilization review   0   0   35.00   35.00   Utilization review   0   35.00   35.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   279,670   0   36.00   37.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   0   37.00   38.00   Subtotal (line 36 ± line 37)   279,670   0   38.00   39.00   Direct graduate medical education payments (from Wkst. E-4)   0   39.00   40.00   Total amount payable to the provider (sum of lines 38 and 39)   279,670   0   40.00   41.00   Interim payments   355,467   0   41.00   42.00   Balance due provider/program (line 40 minus line 41)   -75,797   0   42.00   43.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,   0   0   43.00	28.00			0	0	28. 00
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 0 31.00 30.00 279,670 0 0 32.00 0 33.00 0 0 34.00 0 0 35.00 0 0 36.00 0 37.00 0 36.00 0 37.00 0 36.00 0 37.00 0 36.00 0 37	29.00	Titles V or XIX (sum of lines 21 and 27)		279, 670	0	29. 00
31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  32. 00 Deductibles  32. 00 Deductibles  33. 00 Coinsurance  44. 00 Allowable bad debts (see instructions)  35. 00 Utilization review  36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38. 00 Subtotal (line 36 ± line 37)  39. 00 Direct graduate medical education payments (from Wkst. E-4)  40. 00 Total amount payable to the provider (sum of lines 38 and 39)  41. 00 Interim payments  42. 00 Balance due provider/program (line 40 minus line 41)  43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 0 31. 00  0 31. 00  0 31. 00  0 32. 00  0 32. 00  0 34. 00  35. 00  0 36. 00  37. 00  37. 00  37. 00  37. 00  37. 00  37. 00  37. 00  37. 00  37. 00  37. 00  37. 00  37. 00  37. 00  37. 00  37. 00  37. 00  37. 00  38. 00  39. 00  40. 00  41. 00  42. 00  43. 00		COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
32. 00 Deductibles 0 0 32. 00 33. 00 Coinsurance 0 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 279, 670 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 279, 670 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 279, 670 0 40. 00 41. 00 Interim payments 355, 467 0 41. 00 42. 00 Balance due provider/program (line 40 minus line 41) -75, 797 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00	30.00	Excess of reasonable cost (from line 18)		0	0	30.00
33.00   Coinsurance   0   0   33.00   34.00   Allowable bad debts (see instructions)   0   0   34.00   35.00   Utilization review   0   0   35.00   35.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   279,670   0   36.00   37.00   0   0   0   0   0   0   0   0   0	31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		279, 670	0	31.00
34.00   Allowable bad debts (see instructions)   0   34.00   35.00   Utilization review   0   35.00   36.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   279,670   0   36.00   37.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   0   37.00   38.00   Subtotal (line 36 ± line 37)   279,670   0   38.00   39.00   Direct graduate medical education payments (from Wkst. E-4)   0   37.00   279,670   0   38.00   39.00   Total amount payable to the provider (sum of lines 38 and 39)   279,670   0   40.00   41.00   Interim payments   355,467   0   41.00   42.00   Balance due provider/program (line 40 minus line 41)   -75,797   0   42.00   43.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,   0   43.00	32.00	Deducti bl es		0	0	32. 00
35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Interim payments 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 35. 00 35. 00 36. 00 0 36. 00 0 37. 00 0 37. 00 0 37. 00 0 38. 00 0 39. 00 0 39. 00 0 49. 00 0 41. 00 0 42. 00 0 43. 00	33.00	Coinsurance		0	0	33. 00
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 36.00  0 36.00  279, 670  0 37.00  38.00  279, 670  0 38.00  279, 670  0 39.00  39.00  40.00  41.00 Interim payments  41.00 Balance due provider/program (line 40 minus line 41)  42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	34.00	Allowable bad debts (see instructions)		0	0	34. 00
37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38. 00 Subtotal (line 36 ± line 37)  39. 00 Direct graduate medical education payments (from Wkst. E-4)  40. 00 Total amount payable to the provider (sum of lines 38 and 39)  41. 00 Interim payments  42. 00 Balance due provider/program (line 40 minus line 41)  43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 37. 00  37. 00  37. 00  37. 00  37. 00  37. 00  37. 00  38. 00  39. 00  40. 00  41. 00  42. 00  43. 00  44. 00  45. 00  47. 00  48. 00  49. 00  49. 00  40.	35.00	Utilization review		0		35. 00
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  279, 670 0 38.00 39.00 279, 670 0 40.00 41.00 41.00 42.00 43.00	36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	279, 670	0	36. 00
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  39.00 279, 670 355, 467 0 41.00 42.00 43.00				0	0	
40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 40.00  41.00  42.00  43.00		,		279, 670	0	
41.00 Interim payments 355, 467 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) -75, 797 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00				0		
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 42.00				279, 670		
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00					-	
					-	1
chapter 1, §115.2	43. 00		ce with CMS Pub 15-2,	0	0	43. 00
		Cnapter  , 9115.2				I

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0064	Peri od: From 10/01/2016	Worksheet E-3 Part VII
	Component CCN: 15-S064	To 09/30/2017	Date/Time Prepared: 2/26/2018 10:28 am
	Title XIX	Subprovi der -	Cost

		II ti e xi x	I PF	COST	
			Inpati ent	Outpati ent	
			1, 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	S FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		297, 247		1.00
2. 00	Medical and other services		277,217	0	
3.00	Organ acquisition (certified transplant centers only)		0	· ·	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		297, 247	0	
5. 00	Inpatient primary payer payments		277,217	Ü	5. 00
6.00	Outpatient primary payer payments			0	1
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		297, 247	0	
,, 00	COMPUTATION OF LESSER OF COST OR CHARGES		2777217		7.00
	Reasonable Charges				1
8.00	Routine service charges		42, 241		8.00
9. 00	Ancillary service charges		241, 343	0	
10.00	Organ acquisition charges, net of revenue		0	_	10.00
11. 00	Incentive from target amount computation		o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		283, 584	0	1
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for ser	vices on a charge	0	0	13. 00
	basis	3.			
14.00	Amounts that would have been realized from patients liable for pay	ment for services on	o	0	14. 00
	a charge basis had such payment been made in accordance with 42 CF	R §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		283, 584	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only if	line 16 exceeds	0	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only if	line 4 exceeds line	13, 663	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
20.00	Cost of physicians' services in a teaching hospital (see instructi	ons)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		283, 584	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	leted for PPS provide			
	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	
	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0	0	25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		٩	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		283, 584	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		12 ((2	0	20.00
30.00	Excess of reasonable cost (from line 18)		13, 663	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		283, 584	0	
32. 00	Deducti bl es		0	0	
33.00	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	Ü	
35. 00 36. 00	Utilization review  Subtatal (sum of Lines 21, 24 and 25 minus sum of Lines 22 and 22)		202 504	0	35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		283, 584	0	
	Subtotal (line 36 ± line 37)		202 504	0	
	Direct graduate medical education payments (from Wkst. E-4)		283, 584	U	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		283, 584	0	
41. 00	Interim payments		160, 611	0	
41.00	Balance due provider/program (line 40 minus line 41)		122, 973	0	1
42.00	Protested amounts (nonallowable cost report items) in accordance w	ith CMS Pub 15_2	122, 9/3	0	
73.00	chapter 1, §115.2	1 th 000 1 ab 10-2,		U	75.00
	onapton 1/ 511012		1		1

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

Provider CCN: 15-0064

Peri od: Worksheet G From 10/01/2016 To 09/30/2017 Date/Time Prepared:

onl y)			'	0 09/30/201/	2/26/2018 10:	
		General Fund	Specific Purpose Fund	Endowment Fund		
		1. 00	2. 00	3. 00	4. 00	
1 00	CURRENT ASSETS	2 / 51 512		ا	0	1 00
1. 00 2. 00	Cash on hand in banks Temporary investments	2, 651, 513	C	1	0	1. 00 2. 00
3.00	Notes receivable	0		-	0	3. 00
4. 00	Accounts receivable	5, 173, 248		0	0	4. 00
5. 00	Other recei vabl e	1, 422, 150		Ö	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	0		o	0	6. 00
7.00	Inventory	785, 209	l c	o	0	7. 00
8.00	Prepai d expenses	369, 636	C	0	0	8. 00
9.00	Other current assets	0	C	0	0	9. 00
10.00	Due from other funds	0	C	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	10, 401, 756	C	0	0	11. 00
40.00	FI XED ASSETS	4 000 705	1			10.00
12.00	Land	1, 003, 725	1	-	0	12.00
13. 00 14. 00	Land improvements	471, 366	C		0	13. 00 14. 00
15. 00	Accumulated depreciation Buildings	51, 320, 484	1	0	0	15. 00
16. 00	Accumul ated depreciation	-57, 027, 025		0	0	16. 00
17. 00	Leasehold improvements	1, 143, 979			0	17. 00
18. 00	Accumulated depreciation	0	Ì	o	0	18. 00
19. 00	Fi xed equipment	Ö	d		0	19. 00
20.00	Accumul ated depreciation	0	l c	o	0	20.00
21.00	Automobiles and trucks	0	C	0	0	21. 00
22. 00	Accumulated depreciation	0	C	0	0	22. 00
23.00	Major movable equipment	22, 981, 870	C	0	0	23. 00
24. 00	Accumulated depreciation	0	C	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	C	0	0	25. 00
26. 00	Accumulated depreciation	0		0	0	26. 00
27. 00	HIT designated Assets	0	C	0	0	27. 00
28. 00 29. 00	Accumulated depreciation Minor equipment-nondepreciable	0		0	0	28.00
30. 00	Total fixed assets (sum of lines 12-29)	19, 894, 399		-	0	30.00
30.00	OTHER ASSETS	17,074,377		<u> </u>	0	30.00
31.00	Investments	3, 197, 406	C	0	0	31. 00
32.00	Deposits on Leases	0	l c	o	0	32. 00
33.00	Due from owners/officers	0	C	0	0	33.00
34.00	Other assets	2, 469, 367	C	0	0	34. 00
35.00	Total other assets (sum of lines 31-34)	5, 666, 773		1	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	35, 962, 928	C	0	0	36. 00
07.00	CURRENT LIABILITIES	4 040 007				07.00
37. 00	Accounts payable	4, 319, 206			0	37.00
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	1, 234, 013			0	38. 00 39. 00
40. 00	Notes and Loans payable (short term)	1, 133, 422			0	40.00
41. 00	Deferred income	1, 133, 422 1		0	0	41.00
42. 00	Accel erated payments	0			O	42. 00
43. 00	Due to other funds	Ö		o	0	
44.00	Other current liabilities	461, 597	l c	o	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	7, 148, 238		0	0	
	LONG TERM LIABILITIES					
46.00	Mortgage payable	15, 213, 045		-	0	
47. 00	Notes payable	0	C		0	
48. 00	Unsecured Loans	0	C	-	0	
49. 00	Other long term liabilities	0	C		0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15, 213, 045		1	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	22, 361, 283	C	0	0	51.00
52. 00	CAPITAL ACCOUNTS  General fund balance	13, 601, 645	I			52. 00
53. 00	Specific purpose fund	13,001,043		,		53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted					55. 00
56. 00	Governing body created - endowment fund balance			ol		56. 00
57. 00	Plant fund balance - invested in plant				0	
58.00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansion					
59. 00	Total fund balances (sum of lines 52 thru 58)	13, 601, 645		0	0	
60.00	Total liabilities and fund balances (sum of lines 51 and	35, 962, 928	C	이	0	60.00
	[59]	1	I			I

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0064

0

19.00

Period: Worksheet G-1 From 10/01/2016

09/30/2017 Date/Time Prepared: 2/26/2018 10:28 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 13, 803, 321 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) -201, 676 2.00 3.00 Total (sum of line 1 and line 2) 13, 601, 645 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 13, 601, 645 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 13, 601, 645 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0

19.00

Fund balance at end of period per balance

sheet (line 11 minus line 18)

Health Financial Systems FAY STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0064

				0 09/30/201/	2/26/2018 10:	oared: 28 am
	Cost Center Description		Inpatient	Outpati ent	Total	20 4
			1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES	•				
	General Inpatient Routine Services					
1.00	Hospi tal		4, 008, 160	)	4, 008, 160	1.00
2.00	SUBPROVI DER - I PF		4, 552, 489		4, 552, 489	2.00
3.00	SUBPROVI DER - I RF		1, 087	'	1, 087	3.00
4.00	SUBPROVI DER		(		0	4.00
5.00	Swing bed - SNF		(		0	5.00
6.00	Swing bed - NF		(		0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)		8, 561, 736	b	8, 561, 736	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT		1, 490, 47	'	1, 490, 477	11. 00
12. 00	CORONARY CARE UNIT					12. 00
13. 00	BURN INTENSIVE CARE UNIT					13.00
14. 00	SURGI CAL INTENSIVE CARE UNIT					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of li	nes	1, 490, 477	'	1, 490, 477	16. 00
	11-15)					
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		10, 052, 213		10, 052, 213	17. 00
18.00	Ancillary services		8, 060, 422		62, 951, 032	18. 00
19. 00	Outpati ent servi ces		899, 503		25, 964, 642	19. 00
20.00	RURAL HEALTH CLINIC		(	1	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		(	-	0	21. 00
22. 00	HOME HEALTH AGENCY			19, 071	19, 071	22. 00
23. 00	AMBULANCE SERVICES		(		0	23. 00
24. 00	CMHC					24. 00
25. 00 26. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE		,	18, 528	18, 528	25. 00 26. 00
27. 00	OTHER NONREIMBURSABLE COST CENTERS		6, 415, 812		7, 143, 371	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkc+	25, 427, 950		106, 148, 857	28. 00
26.00	G-3, line 1)	WKSL.	23, 427, 930	00, 720, 907	100, 140, 637	26.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			49, 376, 826		29. 00
30. 00	ADD (SPECIFY)		(			30.00
31. 00	(SI ESTITY)		(	1		31. 00
32. 00			(	Ó		32. 00
33. 00			(	ń		33. 00
34. 00			Č			34. 00
35. 00			(			35. 00
36. 00	Total additions (sum of lines 30-35)			0		36. 00
37. 00	DEDUCT (SPECIFY)		(			37. 00
38. 00			(			38. 00
39.00			(			39.00
40.00			(			40.00
41.00			(			41.00
42.00	Total deductions (sum of lines 37-41)			o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(	(transfer		49, 376, 826		43.00
	to Wkst. G-3, line 4)					
		•		•	•	

Hoal th	Financial Systems FAYETTE REGIONAL HI	ENLTH SYSTEM	Inlie	u of Form CMS-2	2552_10
	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0064	Peri od:	Worksheet G-3	
STATE	ENT OF REVENUES THIS ENTENUES	11001461 0011 10 0001	From 10/01/2016		
					pared:
				2/26/2018 10:	28 am
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	20)		106, 148, 857	1. 00
2.00					2.00
	Less contractual allowances and discounts on patients' account that revenues (line 1 minus line 2)	lS.		64, 349, 406	
3.00	Net patient revenues (line 1 minus line 2)	42)		41, 799, 451	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		49, 376, 826	
5. 00	Net income from service to patients (line 3 minus line 4) OTHER INCOME			-7, 577, 375	5. 00
/ 00	Contributions, donations, bequests, etc			0	/ 00
6.00				_	
7.00	Income from investments			0	
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	
9.00	Revenue from television and radio service			0	7.00
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
	Revenue from laundry and linen service			0	13. 00
	Revenue from meals sold to employees and guests			0	00
15. 00	Revenue from rental of living quarters			0	10.00
	Revenue from sale of medical and surgical supplies to other t	han patients		0	
	Revenue from sale of drugs to other than patients			0	
18. 00	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	1 / 1 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
	OTHER OPERATING REVENUE			6, 305, 087	
	INVESTMEENT RETURN			1, 101, 705	24. 01
24. 02	OTHER NON-OPERATING REVENUE			-2, 035	24. 02
25 00	Total other income (sum of lines 6.24)			7 404 757	25 00

7, 404, 757

-172, 618 26. 00 29, 058 27. 00 29, 058 28. 00 -201, 676 29. 00

25.00

24.02 OTHER NON-OPERATING REVENUE
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 CHANGE IN NET ASSETS OF FOUNDATION
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

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17.00

18.00

19 00

20.00

21.00

22.00

23.00

23.50

24.00

17.00

18.00

19. 00 20. 00

21.00

22.00

23.00

23. 50

Clinic

Private Duty Nursing

Day Care Program

Homemaker Service

Tel emedi ci ne

All Others (specify)

24.00 Total (sum of lines 1-23)

Health Promotion Activities

Home Delivered Meals Program

	Financial Systems LLOCATION - HHA GENERAL SERVICE		YETTE REGIONAL		I CN: 15-0064 15-7097	Peri od: From 10/01/2016 To 09/30/2017	wof Form CMS-2 Worksheet H-1 Part I Date/Time Pre 2/26/2018 10:	
						Home Health	PPS	<u> 20 a</u>
			Capital Rela	 ated Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	PI ant Operation 8 Maintenance		Subtotal (col s. 0-4)	
		0	1.00	2. 00	3.00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS  Capital Related - Bldg. &		O				0	1.00
1.00	Fixtures							1.00
2.00	Capital Related - Movable Equipment	0		C			0	2. 00
3.00	Plant Operation & Maintenance	o	0	C		0	0	3. 00
4.00	Transportation	0	0	C		0 0	22.052	4.00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	22, 953	Ŋ		ή	0 0	22, 953	5. 00
6.00	Skilled Nursing Care	6, 505	0	C	1	0 0	6, 505	1
7. 00 8. 00	Physical Therapy Occupational Therapy	3, 487 2, 783	0	C		0 0	3, 487 2, 783	
9.00	Speech Pathology	0	o	C		0 0	0	9. 00
10. 00 11. 00	Medical Social Services Home Health Aide	1, 375 2, 254	0	C		0 0	1, 375 2, 254	
12. 00	Supplies (see instructions)	2,234	0	C		0 0	2,234	1
13.00	Drugs	0	0	C	1	0	0	
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	C	<u>/ </u>	0 0	0	14. 00
15. 00	Home Dialysis Aide Services	0	0	C	1	0 0	0	
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0	C		0 0	0	16. 00 17. 00
18. 00	Clinic		0	C		0 0	0	
19. 00	Health Promotion Activities	0	0	C		0 0	0	19.00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	C		0 0	0 0	20.00
22. 00	Homemaker Service	0	o	C		0 0	0	22. 00
23. 00 23. 50	All Others (specify) Telemedicine	0	0	C		0 0	0	23. 00 23. 50
24. 00	Total (sum of lines 1-23)	39, 357	0	C	1	0 0	39, 357	24. 00
		Administrative & General	Total (cols. 4A + 5)					
		5. 00	6.00					
1. 00	GENERAL SERVICE COST CENTERS  Capital Related - Bldg. &	1						1.00
1.00	Fixtures							1.00
2.00	Capital Related - Movable							2. 00
3.00	Equipment Plant Operation & Maintenance							3. 00
4.00	Transportation	00.050						4.00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	22, 953						5. 00
6.00	Skilled Nursing Care	9, 102	15, 607					6. 00
7. 00 8. 00	Physical Therapy Occupational Therapy	4, 879 3, 894	8, 366 6, 677					7. 00 8. 00
9. 00	Speech Pathology	0	0					9. 00
10.00	Medical Social Services	1, 924	3, 299					10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	3, 154	5, 408 0					11. 00 12. 00
13.00	Drugs	0	0					13.00
14. 00	HHA NONREI MBURSABLE SERVI CES	0	0					14. 00
15. 00	Home Dialysis Aide Services	0	0					15. 00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0					16. 00 17. 00
18. 00	Clinic	0	0					18. 00
19. 00	Health Promotion Activities	0	0					19.00
20. 00 21. 00	Day Care Program Home Delivered Meals Program		0					20.00
22. 00	Homemaker Service	0	0					22. 00
	All Others (specify) Telemedicine	0	0					23. 00 23. 50
	Total (sum of lines 1-23)		39, 357					24. 00
		·	·					

COST A	Financial Systems LLOCATION - HHA STATISTICAL BAS		AYETTE REGIONAL	Provi der C		Peri od:	worksheet H-1	
				HHA CCN:	15-7097	From 10/01/2016 To 09/30/2017		pared: 28 am
						Home Health Agency I	PPS	
		Capital Rel	ated Costs			rigerie y 1		
		BI dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	PI ant Operation & Mai ntenance (SQUARE FEET)	Transportation (MILEAGE)	on Reconciliation	Administrative & General (ACCUM. COST)	
		1. 00	2.00	3.00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures Capital Related - Movable	0	0			0		1. 00 2. 00
	Equi pment							
3. 00 4. 00	Plant Operation & Maintenance Transportation (see	0	0	0	i .	0		3. 00 4. 00
	instructions)							
5.00	Administrative and General HHA REIMBURSABLE SERVICES	0	0	0		0 -22, 953	16, 404	5. 00
6. 00	Skilled Nursing Care	0	0	0		0 0	6, 505	6.00
7. 00	Physical Therapy	0	0	Ö		0 0	3, 487	
8.00	Occupational Therapy	0	0	0		0 0	2, 783	
9.00	Speech Pathology	0	0	0		0 0	0	1
10.00	Medical Social Services	0	0	0		0 0	1, 375	10.00
11. 00	Home Health Aide	0	0	0		0 0	2, 254	
12.00	Supplies (see instructions)	0	0	0		0 0	0	1
13.00	Drugs	0	0	0		0	0	13. 00
14.00	DME	0	0	0		0 0	0	14. 00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
16.00	Respi ratory Therapy	0	0	0		0	0	16. 00
17.00	Private Duty Nursing	0	0	0		0	0	17. 00
18.00	Clinic	0	0	0		0	0	18. 00
19.00	Health Promotion Activities	0	0	0		0	0	19. 00
20.00	Day Care Program	0	0	0		0	0	20. 00
21.00	Home Delivered Meals Program	0	0	0		0	0	21. 00
22. 00	Homemaker Service	0	0	0		0	0	22. 00
23. 00	All Others (specify)	0	0	0		0	0	
23. 50	Tel emedi ci ne	0	0	0		0	0	23. 50
24. 00	Total (sum of lines 1-23)	0	0	0		0 -22, 953		
25. 00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0		0	22, 953	25. 00
26 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 00000	20	1. 399232	26 00

Health Financial Systems FAYETT ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 2/26/2018 10: 28 am Provider CCN: 15-0064 Peri od: From 10/01/2016 To 09/30/2017 HHA CCN: 15-7097 Home Health PPS

						Home Health Agency I	PPS	
			CAPI TAL			Agency 1		
			RELATED COSTS					
	Cost Center Description	HHA Trial	BLDG & FIXT	EMPLOYEE	Subtotal	ADMI NI STRATI VE		
		Bal ance (1)		BENEFITS DEPARTMENT		& GENERAL	PLANT	
		0	1.00	4. 00	4A	5. 00	7. 00	
1.00	Administrative and General	0		5, 998	5, 998		0	1. 00
2.00	Skilled Nursing Care	15, 607	0	0	15, 607	3, 043	0	2. 00
3.00	Physi cal Therapy	8, 366	1	0	8, 366		0	3. 00
4.00	Occupational Therapy	6, 677	0	0	6, 677		0	4. 00
5. 00 6. 00	Speech Pathology Medical Social Services	3, 299	0	0	3, 299	0 643	0	5. 00 6. 00
7. 00	Home Heal th Aide	5, 408		o	5, 408		0	7. 00
8.00	Supplies (see instructions)	0		ō	0, 110	0	0	
9.00	Drugs	0	_	0	C	0	0	9. 00
10.00	DME	0	0	0	C	0	0	10.00
11. 00 12. 00	Home Dialysis Aide Services	0	0	0	Ü	0	0	11. 00 12. 00
13. 00	Respiratory Therapy Private Duty Nursing	0	0	0	0	0	0	13. 00
14. 00	Clinic	0	0	o	Ö	o o	0	14. 00
15. 00	Health Promotion Activities	0	0	О	C	0	0	15. 00
16. 00	Day Care Program	0	0	0	C	0	0	16. 00
17. 00	Home Delivered Meals Program Homemaker Service	0	0	0	0	0	0	17. 00
18. 00 19. 00	All Others (specify)		0	0	0	0	0	18. 00 19. 00
19. 50		0	0	o	Ö	o o	0	19. 50
20.00	Total (sum of lines 1-19) (2)	39, 357	0	5, 998	45, 355	8, 842	0	20. 00
21. 00	Unit Cost Multiplier: column				0. 000000			21. 00
	26, line 1 divided by the sum of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	6 decimal places.	PLANT	LINEN SERVICE				ADMI NI STRATI ON	
1. 00	6 decimal places.		LINEN SERVICE 8.00	HOUSEKEEPI NG  9.00 0	DI ETARY  10. 00	11.00		1. 00
2.00	6 decimal places.  Cost Center Description  Administrative and General Skilled Nursing Care	PLANT 7. 01	8.00 0	9.00	10. 00	11.00	ADMI NI STRATI ON 13. 00 10, 130 0	2. 00
2. 00 3. 00	6 decimal places.  Cost Center Description  Administrative and General Skilled Nursing Care Physical Therapy	PLANT 7. 01	8.00 0 0	9. 00 0 0	10. 00	11.00	ADMI NI STRATI ON 13. 00 10, 130 0 0	2. 00 3. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	PLANT 7. 01	8.00 0 0 0 0	9.00 0 0 0	10. 00	11.00	ADMI NI STRATI ON 13. 00 10, 130 0 0 0	2. 00 3. 00 4. 00
2.00 3.00 4.00 5.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	PLANT 7. 01	8.00 0 0 0 0 0	9.00 0 0 0 0	10. 00 C C C	11. 00 2, 556 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	PLANT 7. 01	8.00 0 0 0 0	9.00 0 0 0	10. 00	11. 00 2, 556 0 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	PLANT 7. 01	8. 00 0 0 0 0 0 0	9.00 0 0 0 0	10. 00 C C C C	11. 00 2, 556 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	PLANT 7. 01	8.00 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0	10.00 C C C C C	11. 00 2, 556 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	PLANT 7. 01	8.00 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0	10.00	11. 00 2, 556 0 0 0 0 0 0 0 0	ADMI NI STRATI ON  13. 00  10, 130  0  0  0  0  0  0  0  0  0  0  0  0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	PLANT 7. 01	8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0	10.00 C C C C C	11. 00 2, 556 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	PLANT 7. 01	8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0	10.00	11. 00 2, 556 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	PLANT 7. 01	8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0	10.00	11. 00 2, 556 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	PLANT 7. 01	8.00 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0	10.00	11. 00 2, 556 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	PLANT 7. 01	8.00 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 2, 556 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	PLANT 7. 01	B. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 2, 556 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	PLANT 7. 01	8.00 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 2, 556 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	PLANT 7. 01	8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 2, 556 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	PLANT 7. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 2, 556 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 14.00 15.00 16.00 17.00 18.00 19.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	PLANT 7. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 2, 556 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	PLANT 7. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 2, 556 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	PLANT 7. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 2, 556 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	PLANT 7. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	11. 00 2, 556 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI ON 13. 00 10, 130 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00

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

		HHA CCN:			Date/Time Pre	
				Home Health	PPS	
CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown	Subtotal	
14. 00	15. 00	16. 00	24. 00	25. 00	26. 00	
	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	300 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	18, 65 9, 99 7, 97 3, 94 6, 46	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20, 153 18, 650 9, 997 7, 979 0 3, 942 6, 462 0 0 0 0 0 0 0 0 0 0 0 0 0 0 67, 183	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 19. 50
A&G (see Part	Costs					
27. 00	28. 00					1. 00
7, 992 4, 284 3, 419 0 1, 689 2, 769 0 0 0 0 0 0 0 0 0 20, 153 0. 428514	26, 642 14, 281 11, 398 0 5, 631 9, 231 0 0 0 0 0 0 0 0 0 0					2. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 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
	SERVICES & SUPPLY  14.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVICES & SUPPLY  14. 00	CENTRAL SERVICES & SUPPLY  14. 00  15. 00  0 0 0 300  0 0 0 0 0 0 0 0 0 0 0 0	CENTRAL SERVICES & SUPPLY  14. 00  15. 00  16. 00  24. 00  18. 65  0 0 0 0 0 7, 97  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Home Heal th Agency   SERVICES & SUPPLY   PHARMACY   RECORDS & LI BRARY   Residents Cost & Post Stepdown Adjustments   Septown Adj	HHA CCN: 15-7097   TO 09/30/2017   Date/Time Pre 2/26/2018 10: 2/26/20

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

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO BASIS		Peri od: Worksheet H-2 From 10/01/2016 Part II
	HHA CCN: 15-7097	To 09/30/2017 Date/Time Prepared:

2/26/2018 10:28 am

Home Health PPS Agency I CAPI TAL RELATED COSTS **EMPLOYEE** Reconciliation ADMINISTRATIVE OPERATION OF OPERATION OF Cost Center Description BLDG & FIXT (SQUARE FEET) **BENEFITS** & GENERAL **PLANT** PI ANT DEPARTMENT (ACCUM. COST) (SQUARE FEET) (SQUARE FEET) (GROSS SALARI ES) 1.00 5A 5.00 7. 00 7. 01 4.00 0 5. 998 1.00 Administrative and General 24, 425 C 0 1.00 2.00 Skilled Nursing Care 0 15, 607 0 0 0 0 0 0 0 0 0 0 2.00 3.00 Physical Therapy 0 8, 366 3.00 0 0 0 000000000000 Occupational Therapy 4.00 0 6,677 0 4.00 0 5.00 Speech Pathology  $\Gamma$ 5.00 6.00 Medical Social Services 0 3, 299 6.00 7.00 Home Health Aide 0 0 0 5, 408 7.00 8.00 0 8.00 Supplies (see instructions) 0 0 9.00 Drugs C 0 9.00 10.00 DMF 0 10.00 0 11.00 Home Dialysis Aide Services 0 0 11.00 0 12.00 Respiratory Therapy 0 0 12.00 13.00 Private Duty Nursing 0 13.00 0 14.00 Clinic 0 0 0 0 0 0 0 14.00 Health Promotion Activities 15.00 C 0 15.00 0 16.00 Day Care Program 16.00 0 17.00 Home Delivered Meals Program 0 0 0 17.00 0 Homemaker Service 18.00 18.00 0 0 All Others (specify) 0 19.00 19.00 0 0 19.50 Tel emedi ci ne 0 0 19.50 Total (sum of lines 1-19) 20.00 24, 425 45, 355 20.00 21.00 Total cost to be allocated 5. 998 8.842 21.00 0.000000 0. 245568 0.194951 0.000000 22.00 Unit cost multiplier 0.000000 22.00 Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL LINEN SERVICE (SQUARE FEET) (MEALS SERVED) (MAN HOURS) ADMI NI STRATI ON SERVICES & (POUNDS OF **SUPPLY** LAUNDRY) (FTE'S) (100%)9.00 10.00 11.00 13.00 14.00 8.00 1.00 Administrative and General 0 2,079 100 1.00 2.00 Skilled Nursing Care 0 0000000000000000000 0 0 2.00 0 0 0 Physical Therapy 0 0 0 3.00 3.00 0 Occupational Therapy 0 4.00 4.00 5.00 Speech Pathology 0 0 5.00 0 0 6.00 Medical Social Services 0 0 0 0 0 0 6.00 0 7.00 Home Health Aide 0 0 O 7.00 0 8.00 Supplies (see instructions) 0 8.00 9.00 9.00 Drugs 0 0 10.00 DME 0 10.00 0 0 Home Dialysis Aide Services 11 00 Ω 11 00 12.00 Respiratory Therapy 0 12.00 0 0 13.00 Private Duty Nursing 0 0 13.00 0 Ω 0 14 00 14 00 Clinic 0 0 15.00 Health Promotion Activities 15.00 Day Care Program 0 0 0 0 0 16.00 16.00 0 0 17.00 Home Delivered Meals Program 0 17.00 0 0 18 00 Homemaker Service Ω 18 00 19.00 All Others (specify) 0 0 0 19.00 19. 50 Tel emedi ci ne 0 0 0 19.50 20.00 Total (sum of lines 1-19) 0 0 0 2,079 100 20.00 0 Total cost to be allocated 0 21.00 0 2.556 10, 130 21 00

0.000000

0.000000

0.000000

1. 229437

101. 300000

0. 000000

22.00

22.00 Unit cost multiplier

Heal th	Financial Systems	FA	YETTE REGIONAL HI	EALTH SYSTEM		In Lie	u of Form CMS-	2552-10
	TION OF GENERAL SERVICE COSTS T	O HHA COST CENT	TERS STATISTICAL	Provi der CCN:	15-0064	Peri od:	Worksheet H-2	
BASIS				HHA CCN:	15-7097	From 10/01/2016 To 09/30/2017	Part II   Date/Time Pre	nared.
				111111 0014.	10 7077	077 007 2017	2/26/2018 10:	
						Home Health	PPS	
						Agency I		
	Cost Center Description	PHARMACY	MEDI CAL					
		(100%)	RECORDS &					
			LI BRARY (GROSS					
			CHARGES)					
		15. 00	16. 00					1
1. 00	Administrative and General	0	19, 071					1. 00
2.00	Skilled Nursing Care	0	0					2. 00
3.00	Physi cal Therapy	0	0					3. 00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5. 00
6.00	Medical Social Services	0	0					6. 00
7.00	Home Health Aide	0	0					7. 00
8.00	Supplies (see instructions)	0	0					8. 00
9.00	Drugs	0	0					9. 00
10.00	DME	0	0					10. 00
11. 00	Home Dialysis Aide Services	0	0					11. 00
12.00	Respi ratory Therapy	0	0					12. 00
13.00	Private Duty Nursing	0	0					13. 00
14. 00	Clinic	0	0					14. 00
	Health Promotion Activities	0	0					15. 00
	Day Care Program	0	0					16. 00
	Home Delivered Meals Program	0	0					17. 00
	Homemaker Service	0	0					18.00
	All Others (specify)	0	0					19.00
	Telemedicine	0	10, 071					19. 50
20.00	Total (sum of lines 1-19)	0	19, 071					20.00
21. 00	Total cost to be allocated	0. 000000	300 0. 015731					21.00
22.00	Unit cost multiplier	0.000000	0. 015/31					22.00

Heal th	Financial Systems	F	YETTE REGIONAL	HEALTH SYSTEM	1	In lie	eu of Form CMS-2	2552_10
	TIONMENT OF PATIENT SERVICE COST		TETTE REGIONAL		CN: 15-0064	Peri od: Worksheet I		
				HHA CCN:	15-7097	From 10/01/2016 To 09/30/2017	Part I Date/Time Pre	pared:
				Ti +I /	e XVIII	Home Health	2/26/2018 10: PPS	28 am_
				11 (1)	e valii	Agency I	PPS	
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from Part II)	+ 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							
1 00	Cost Per Visit Computation	2.00	2/ /42		2/ /	40 000	110 47	1 00
1. 00 2. 00	Skilled Nursing Care Physical Therapy	2. 00 3. 00	· ·	(	26, 6 14, 2			1. 00 2. 00
3.00	Occupational Therapy	4.00			1		l .	1
4. 00	Speech Pathology	5. 00				0 0		
5.00	Medical Social Services	6. 00	5, 631		5, 6	31 C	0.00	5. 00
6.00	Home Health Aide	7. 00	9, 231		9, 2			6. 00
7. 00	Total (sum of lines 1-6)		67, 183	(	67, 1			7. 00
			I		Program Visi			
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	art B to Subject to		
	cost center bescription	COST LIMITES	CDSA NO. (1)	rait A	Deducti bl es			
					Coi nsurance			
		0	1.00	2.00	3.00	4. 00	5. 00	
0.00	Limitation Cost Computation	T	47440		J		T	0.00
8. 00 8. 01	Skilled Nursing Care Skilled Nursing Care		17140 99915	(	1	9 42		8. 00 8. 01
9. 00	Physical Therapy		17140		1	0		9. 00
9. 01	Physical Therapy		99915		1	14		9. 01
10.00	Occupational Therapy		17140	C		14		10.00
10. 01	Occupational Therapy		99915	(		8		10. 01
11. 00	Speech Pathology		17140	(	1	0		11. 00
11. 01	Speech Pathology		99915	(		0		11. 01
12.00	Medical Social Services		17140	(	2	0		12.00
12. 01 13. 00	Medical Social Services Home Health Aide	•	99915 17140	(		0 17	•	12. 01 13. 00
13. 00	Home Health Aide		99915			39		13. 00
	Total (sum of lines 8-13)		77713		1	43		14. 00
	Cost Center Description	From Wkst. H-2	Facility Costs		Total HHA		Ratio (col. 3	
	•	Part I, col.	(from Wkst.	Ancillary	Costs (cols.		÷ col . 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)		
		0	1.00	Part II)	2.00	4.00	F 00	
	Supplies and Drugs Cost Comput	ations	1.00	2. 00	3.00	4. 00	5. 00	
15. 00		8. 00	0	(		0 0	0. 000000	15. 00
16.00	1	9. 00		C	1	0 0		
	-		Program Visits		Cost of			
					Servi ces			
	Cook Cooker Doorsinties	D A	Par		D	Part B	Code:+ +-	
	Cost Center Description	Part A	Not Subject to Deductibles &	,	Part A	Not Subject to Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7. 00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION							
4 00	Cost Per Visit Computation	1 -	= =1				1	4
1.00	Skilled Nursing Care	0	51			0 6, 093		1.00
2. 00 3. 00	Physical Therapy Occupational Therapy	0	14 22			0 10, 523 0 11, 398		2. 00 3. 00
3. 00 4. 00	Speech Pathology		22			0 11, 398		4.00
5.00	Medical Social Services		0			0 0		5. 00
6. 00	Home Heal th Aide	0	56			0 4, 103		6. 00
7. 00	Total (sum of lines 1-6)	0	143			0 32, 117	l .	7. 00
			•					

Heal th	Financial Systems	F <i>A</i>	YETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provi der C	CN: 15-0064	Peri od: From 10/01/2016	Worksheet H-3 Part I	
				HHA CCN:	15-7097	To 09/30/2017	Date/Time Pre 2/26/2018 10:	
				Title	× XVIII	Home Health Agency I	PPS	20 4111
	Cost Center Description							
	Limitation Cost Computation	6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
8. 00 8. 01 9. 00 9. 01 10. 00 10. 01 11. 00 11. 01 12. 00 12. 01 13. 00	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Health Aide							8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 12. 01 13. 00
13. 01	Home Heal th Aide							13. 01
14. 00	Total (sum of lines 8-13)	Donor			0+ -6			14. 00
		Progi	ram Covered Cha	arges	Cost of Services			
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance		Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
	Supplies and Drugs Cost Computation Cost of Medical Supplies Cost of Drugs	o o	0	0	1	0 0	0	
.0.00	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00				3		
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LI	MITATION COST, OR	}	
1. 00	Cost Per Visit Computation Skilled Nursing Care	6, 093						1.00
2. 00 3. 00 4. 00 5. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	10, 523 11, 398 0						2. 00 3. 00 4. 00 5. 00
6. 00	Home Heal th Aide	4, 103						6. 00
7. 00	Total (sum of lines 1-6)	32, 117						7. 00
	Cost Center Description	12. 00						-
	Limitation Cost Computation	12.00						
8. 00 8. 01 9. 00 9. 01 10. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy							8. 00 8. 01 9. 00 9. 01 10. 00
10. 01 11. 00 11. 01 12. 00 12. 01 13. 00	Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide							10. 0° 11. 0° 11. 0° 12. 0° 13. 0° 13. 0°
	Total (sum of lines 8-13)							14. 0

Heal th	Financial Systems	F.A	YETTE REGIONAL	_ HEALTH SYSTEM In Lieu			u of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COST	S		Provi der Co	Provider CCN: 15-0064 Per		Worksheet H-3	
						From 10/01/2016		
				HHA CCN:	15-7097	To 09/30/2017	Date/Time Prep 2/26/2018 10:	
				Title	· XVIII	Home Health	PPS	ZO alli
				11 11 0	, , , , , , , , , , , , , , , , , , , ,	Agency I	113	
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	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	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN			
1.00	Physi cal Therapy	66. 00	0. 595193	0	)	0 col. 2, line 2	. 00	1. 00
2.00	Occupational Therapy							2. 00
3.00	Speech Pathology							3. 00
4.00	Cost of Medical Supplies	71. 00	0. 490042	0	1	0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73.00	0. 333526	0	)	0 col. 2, line 1	6. 00	5. 00

	Financial Systems FAYETTE REGIONAL HE TION OF HHA REIMBURSEMENT SETTLEMENT.	Provider CC	CN: 15-0064	Peri od	:	u of Form CMS-2 Worksheet H-4	
		HHA CCN:	15-7097		0/01/2016 9/30/2017		pare
		Title	XVIII		Health	PPS	
			Part A	Dedu	Subject to ctibles &	Deductibles &	
		-	1.00		nsurance 2.00	Coi nsurance 3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO Reasonable Cost of Part A & Part B Services	DMARY CHARGES			2.00	3.00	
0	Reasonable cost of services (see instructions) Total charges			0	0 15, 995	0	
	Customary Charges Amount actually collected from patients liable for payment for	r servi ces		0	0	0	3
0	on a charge basis (from your records) Amount that would have been realized from patients liable for			0	0	0	4
ŀ	for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)	accordance					
	Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions)		0. 0000	0	0. 000000 15, 995	0. 000000 0	
0	Excess of total customary charges over total reasonable cost (only if line 6 exceeds line 1)	(complete		0	15, 995	0	
	Excess of reasonable cost over customary charges (complete onl 1 exceeds line 6)	yifline		0	0	0	
0	Primary payer amounts			0	o Part A	Part B	(
				Se	ervi ces 1.00	Servi ces 2. 00	
-	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions)				0	0	10
- 1	Total PPS Reimbursement - Full Episodes without Outliers				0	11, 174	
	Total PPS Reimbursement - Full Episodes with Outliers				0	0	
4	Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes				0	120 3, 712	
	Total PPS Outlier Reimbursement - Full Episodes with Outliers				0	0,712	
1	Total PPS Outlier Reimbursement - PEP Episodes				0	0	10
	Total Other Payments				0	0	
1	DME Payments				0	0	
- 1	Oxygen Payments Prosthetic and Orthotic Payments				0	0	
	Part B deductibles billed to Medicare patients (exclude coinsu	urance)			Ü	0	
00	Subtotal (sum of lines 10 thru 20 minus line 21)	*			0	15, 006	
	Excess reasonable cost (from line 8)				0	0	
1	Subtotal (line 22 minus line 23)				0	15, 006	
	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)				0	0 15, 006	
	Reimbursable bad debts (from your records)				U	13,000	2
	Reimbursable bad debts for dual eligible beneficiaries (see in	nstructions)					28
	Total costs - current cost reporting period (line 26 plus line	e 27)			0	15, 006	
1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	0	
	Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration	S)			0	0	
	Demonstration payment adjustment amount before sequestration  Subtotal (see instructions)				0	0 15, 006	
	Sequestration adjustment (see instructions)				0	300	
1	Demonstration payment adjustment amount after sequestration				0	0	1 .
	Interim payments (see instructions)				0	14, 706	
	Tentative settlement (for contractor use only)				0	0	
	Balance due provider/program (line 31 minus lines 31.01, 32, a Protested amounts (nonallowable cost report items) in accordan		Dub 15 0		0	0	
	PLOTESTED AMOUNTS INONALLOWANTE COST PENORT LIEMS) IN ACCORDA	ice with CMS	PUD 15-7	1	()	0	1 4

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIES

FAYETTE REGIONAL HEALTH SYSTEM
Provider CC In Lieu of Form CMS-2552-10
Worksheet H-5 Provider CCN: 15-0064 Peri od: From 10/01/2016 To 09/30/2017 Date/Time Prepared: 2/26/2018 10:28 am HHA CCN: 15-7097

				Home Health Agency I	PPS	<u></u>
		Inpatien	t Part A		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	14, 706	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider			0	0	3. 01
3. 02				0		3. 02
3. 03				Ö	o o	3. 03
3.04				0	0	3.04
3.05				0	0	3. 05
0.50	Provider to Program		I			0 50
3. 50 3. 51				0	0 0	3. 50 3. 51
3. 51				0		3. 52
3. 53				0	o o	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4 00	3. 50-3. 98)				44.70/	4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate,			0	14, 706	4. 00
	line 32)					
	TO BE COMPLETED BY CONTRACTOR		<u>'</u>			
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	Flogiali to Flovidei			0	0	5. 01
5. 02				0	o o	5. 02
5.03				0	0	5. 03
	Provider to Program		1			
5. 50				0	0	5. 50
5. 51 5. 52				0	0 0	5. 51 5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 99
	5. 50-5. 98)				-	
6.00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)					. 01
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0	0 0	6. 01 6. 02
6. 02 7. 00	Total Medicare program liability (see instructions)			0	14, 706	7. 00
7.00	Total mode od. o program redoring (300 mode dottons)			Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
0.00		(	)	1. 00	2. 00	
8.00	Name of Contractor			I	]	8. 00

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS Peri od: From 10/01/2016 To 09/30/2017 Provider CCN: 15-0064 Worksheet 0 Date/Ti me Prepared: 2/26/2018 10:28 am Hospi ce CCN: 15-1548

CREENAL SERVICE COST CENTERS							2/26/2018 10:	28 am
1 plus col_ 2   2 CATIONS						Hospi ce I		
ONLINE   CONTINUE COST CENTERS   1.00   2.00   3.00   4.00   5.00			SALARIES	OTHER			SUBTOTAL	
SEMERAL SERVICE COST CENTERS			1 00					
1.00			1.00	2.00	3.00	4. 00	5. 00	
2.00 CAP REL COSTS-MYBLE EQUIP" 4.00 ADM IN STRATIVE & GENERAL* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								1
3.00 EMPLOYEE BEREFITS DEPARTMENT*  0								
A.O.   ADMINISTRATIVE & CENERAL*   0   0   0   0   0   0   0   0   0				(	0 0	0		
5.00   PLANT OPERATION & MAINTENANCE*   0   0   0   0   0   0   0   0   0	3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	(	0	0	0	3. 00
6.00   LAUNDRY & LINEN SERVICE*   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00	ADMINISTRATIVE & GENERAL*	0	(	0	0	0	4. 00
7.00   HOUSEKEEPING*   0   0   0   0   0   7.00   9.00   NURSING ADMINISTRATION*   0   0   0   0   0   0   0   9.00   NURSING ADMINISTRATION*   0   0   0   0   0   0   9.00   MURSING ADMINISTRATION*   0   0   0   0   0   11.00   MEDICAL RECORDS*   0   0   0   0   0   11.00   MEDICAL RECORDS*   0   0   0   0   0   12.00   STAFF TRANSPORTATION*   0   0   0   0   0   13.00   VOLUNTEER SERVICE COORDINATION*   0   0   0   0   0   0   15.00   PHYSICIAN ADMINISTRATIVE SERVICES*   0   0   0   0   0   0   15.00   PHYSICIAN ADMINISTRATIVE SERVICES*   0   0   0   0   0   0   16.00   OTHER GENERAL SERVICES*   0   0   0   0   0   0   15.00   17.00   PATIENT CARE-CONTRACTED**   0   0   0   0   0   0   15.00   18.01   PATIENT CARE-CONTRACTED**   0   0   0   0   0   0   0   0   27.00   NURSE PRACTITIONER**   0   0   0   0   0   0   25.00   28.00   ROSS STREED NURSES**   0   0   0   0   0   0   25.00   29.00   LINIVALY**   0   0   0   0   0   0   27.00   29.00   LINIVALY**   0   0   0   0   0   0   27.00   29.00   LINIVALY**   0   0   0   0   0   0   27.00   20.00   COLUPATIONAL THERROPY**   0   0   0   0   0   0   27.00   23.00   MEDICAL SERVICES**   0   0   0   0   0   0   33.00   23.00   MEDICAL SERVICES**   0   0   0   0   0   0   33.00   24.00   SECENTIAL CARE SERVICES**   0   0   0   0   0   0   33.00   25.00   DISTANCIAL THERROPY**   0   0   0   0   0   0   0   33.00   25.00   DISTANCIAL THERROPY**   0   0   0   0   0   0   0   33.00   25.00   DISTANCIAL THERROPY**   0   0   0   0   0   0   0   33.00   25.00   DISTANCIAL THERROPY**   0   0   0   0   0   0   0   33.00   25.00   DISTANCIAL THERROPY**   0   0   0   0   0   0   0   33.00   25.00   DISTANCIAL THERROPY**   0   0   0   0   0   0   0   0   0	5.00	PLANT OPERATION & MAINTENANCE*	0	(	0 0	0	0	5. 00
7.00   HOUSEKEEPING*   0   0   0   0   0   7.00   9.00   NURSING ADMINISTRATION*   0   0   0   0   0   0   0   9.00   NURSING ADMINISTRATION*   0   0   0   0   0   0   9.00   MURSING ADMINISTRATION*   0   0   0   0   0   11.00   MEDICAL RECORDS*   0   0   0   0   0   11.00   MEDICAL RECORDS*   0   0   0   0   0   12.00   STAFF TRANSPORTATION*   0   0   0   0   0   13.00   VOLUNTEER SERVICE COORDINATION*   0   0   0   0   0   0   15.00   PHYSICIAN ADMINISTRATIVE SERVICES*   0   0   0   0   0   0   15.00   PHYSICIAN ADMINISTRATIVE SERVICES*   0   0   0   0   0   0   16.00   OTHER GENERAL SERVICES*   0   0   0   0   0   0   15.00   17.00   PATIENT CARE-CONTRACTED**   0   0   0   0   0   0   15.00   18.01   PATIENT CARE-CONTRACTED**   0   0   0   0   0   0   0   0   27.00   NURSE PRACTITIONER**   0   0   0   0   0   0   25.00   28.00   ROSS STREED NURSES**   0   0   0   0   0   0   25.00   29.00   LINIVALY**   0   0   0   0   0   0   27.00   29.00   LINIVALY**   0   0   0   0   0   0   27.00   29.00   LINIVALY**   0   0   0   0   0   0   27.00   20.00   COLUPATIONAL THERROPY**   0   0   0   0   0   0   27.00   23.00   MEDICAL SERVICES**   0   0   0   0   0   0   33.00   23.00   MEDICAL SERVICES**   0   0   0   0   0   0   33.00   24.00   SECENTIAL CARE SERVICES**   0   0   0   0   0   0   33.00   25.00   DISTANCIAL THERROPY**   0   0   0   0   0   0   0   33.00   25.00   DISTANCIAL THERROPY**   0   0   0   0   0   0   0   33.00   25.00   DISTANCIAL THERROPY**   0   0   0   0   0   0   0   33.00   25.00   DISTANCIAL THERROPY**   0   0   0   0   0   0   0   33.00   25.00   DISTANCIAL THERROPY**   0   0   0   0   0   0   0   33.00   25.00   DISTANCIAL THERROPY**   0   0   0   0   0   0   0   0   0	6.00	LAUNDRY & LINEN SERVICE*	0	(	0	0	0	6. 00
9.00 NURSING ADMINISTRATION* 0 0 0 0 0 0 0 0 0 0 0 0 0 10.00 11.00 NEDICAL RECORDS* 0 0 0 0 0 0 0 0 11.00 11.00 NEDICAL RECORDS* 0 0 0 0 0 0 0 0 12.00 13.00 VOLUNTEER SERVICE COORDINATION* 0 0 0 0 0 0 0 0 0 12.00 13.00 STAFF TRANSPORTATION* 0 0 0 0 0 0 0 0 0 12.00 15.00 PHYSICI AN ADMINISTRATIVE SERVICES* 0 0 0 0 0 0 0 0 0 15.00 16.00 OTHER GENERAL SERVICES* 0 0 0 0 0 0 0 0 0 15.00 17.00 PATIENT/RESIDENTIAL CARE SERVICES* 0 0 0 0 0 0 0 0 0 15.00 17.00 DATE PATIENT CARE-CONTRACTED** 17.00 DATE INTIMESIDENTIAL CARE SERVICES* 17.00 NURSE PRACTITIONER** 25.00 INPATIENT CARE-CONTRACTED** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00		0	(	ol c	0	0	7. 00
10.00   ROUTH INE MEDICAL SUPPLIES*   0   0   0   0   0   11.00	8.00	DI ETARY*	0	(	ol c	0	0	8. 00
11.00   MEDICAL RECORDS*   0   0   0   0   0   11.00   12.00   13.00   13.00   12.00   13.00	9.00	NURSING ADMINISTRATION*	0	(	ol c	0	0	9. 00
11.00   MEDICAL RECORDS*   0   0   0   0   0   11.00   12.00   13.00   13.00   12.00   13.00	10.00	ROUTINE MEDICAL SUPPLIES*	o	(	ol d	0	0	10.00
12.00   STAFF TRANSPORTATION*   0   0   0   0   0   0   13.00     13.00   VOLUNTEER SERVICE COORDINATION*   0   0   0   0   0   0   0   14.00     14.00   PHARMACY*   0   0   0   0   0   0   0   15.00     15.00   PHYSICIAN ADMINISTRATIVE SERVICES*   0   0   0   0   0   0   15.00     16.00   OTHER GENERAL SERVICE*   0   0   0   0   0   0   16.00     17.00   DIRECT PATIENT CARE SERVICES   0   0   0   0   0   0   16.00     17.00   DIRECT PATIENT CARE-CONTRACTED**   0   0   0   0   0   0   25.00     10.00   NURSE PRACTITIONER**   0   0   0   0   0   0   25.00     10.00   NURSE PRACTITIONER**   0   0   0   0   0   0   0   27.00     10.00   LPN/LVN**   0   0   0   0   0   0   0   0   0			0	(		0		1
13.0   VOLUNTERS SERVIC C COORDINATION*			0	(		0	0	1
14. 00   PHARMACY*   0   0   0   0   0   0   15. 00     15. 00   PHYSI CIAN AND NI STRATIVE SERVICES*   0   0   0   0   0   0   15. 00     17. 00   OTHER GENERAL SERVICE*   0   0   0   0   0   0   0   15. 00     17. 00   OTHER GENERAL SERVICES   0   0   0   0   0   0   0   0   0     17. 00   OTHER GENERAL SERVICES   0   0   0   0   0   0   0   0     17. 00   OTHER GENERAL SERVICES   0   0   0   0   0   0   0   0   0			0	(		0		
15.00   PHYSICIAN ADMINISTRATIVE SERVICES*			o o			0		
16. 00   OTHER GENERAL SERVICE*   0   0   0   0   0   16. 00			o o	·		0		
17. 00   PATI ENT/RESIDENTI AL CARE SERVICES				ì		0		
DIRECT PATIENT CARE SERVICE COST CENTERS				`	٦		O	
25. 00	17.00							17.00
26. 00   PHYSICIAN SERVICES**   0   0   0   0   0   0   26. 00	25 00						0	25 00
27. 00   NURSE PRACTITIONER**			-		·	0		
28. 00 REGISTERED NURSE** 0 0 0 0 0 121 121 28. 00 29. 00 LPN/LVN** 0 0 0 0 0 0 0 0 0 0 0 29. 00 30. 00 PhySi CAL THERAPY** 0 0 0 0 0 0 0 0 0 0 30. 00 31. 00 0 0 0 0 0 0 0 0 0 0 0 31. 00 0 0 0 0 0 0 0 0 0 0 31. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				(	-	0		
29. 00   LPN/LVM**			0	(	٦	١	-	
30. 00   PHYSI CAL THERAPY**			0	(	٦			
31. 00   OCCUPATIONAL THERAPY**   0   0   0   0   0   31. 00   32. 00   SPECH/LANGUAGE PATHOLOGY**   0   0   0   0   0   32. 00   33. 00   MEDI CAL SOCI AL SERVI (CES**   0   0   0   0   0   0   34. 00   34. 00   35. 00   DETARY COUNSELI NG**   0   0   0   0   0   0   0   34. 00   35. 00   DETARY COUNSELI NG**   0   0   0   0   0   0   0   35. 00   0   0   0   0   0   0   0   0   0			0	(	٦ ٣	١		1
32. 00 SPEECH/LANGUAGE PATHOLOGY** 0 0 0 0 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES** 0 0 0 0 0 0 0 34. 00 33. 00 MEDI CAL SOCI AL SERVI CES** 0 0 0 0 0 0 0 0 0 34. 00 35. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	(	·			
33. 00 MEDI CAL SOCI AL SERVI CES** 0 0 0 0 0 0 43 43 33. 00 34. 00 SPIRITUAL COUNSELI NG** 0 0 0 0 0 0 0 35. 00 35. 00 DI ETARY COUNSELI NG** 0 0 0 0 0 0 0 35. 00 36. 00 COUNSELI NG - OTHER** 0 0 0 0 0 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES** 0 0 0 0 0 0 0 38. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON** 0 0 0 0 0 0 0 39. 00 40. 00 I MAGI NG SERVI CES** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			- I	(		0		
34. 00   SPIRITUAL COUNSELING**			١	(	٦	0		
35. 00 DI ETARY COUNSELING** 0 0 0 0 0 0 0 35. 00 36. 00 COUNSELING - OTHER** 0 0 0 0 0 0 0 36. 00 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 0 0 0 0 0 0 0 0 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON** 0 0 0 0 0 0 0 39. 00 40. 00 IMAGI NG SERVI CES** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			- I	(	٦ ٣	43		1
36. 00 COUNSELING - OTHER**  0 0 0 0 0 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES**  0 0 0 0 0 0 0 0 37. 00 38. 00 DURABLE MEDI CAL EQUIPMENT/OXYGEN**  0 0 0 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON**  0 0 0 0 0 0 0 0 39. 00 40. 00 IMAGI NG SERVI CES**  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				(	٦ ٣	0		1
37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES** 0 0 0 0 0 0 0 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON** 0 0 0 0 0 0 39. 00 40. 00 IMAGI NG SERVI CES** 0 0 0 0 0 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS** 0 0 0 0 0 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 4,847 4,847 0 4,847 42. 00 44. 00 OUTPATI ENT SERVI CES** 0 0 0 0 0 0 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 45. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 45. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) ** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				(				1
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON** 0 0 0 0 0 0 39. 00 40. 00 IMAGI NG SERVI CES** 0 0 0 0 0 0 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS** 0 0 0 0 0 0 0 0 41. 00 42. 00 MEDI CAL SUPPLIES-NON-ROUTI NE** 0 4, 847 4, 847 0 4, 847 42. 00 43. 00 OUTPATI ENT SERVI CES** 0 0 0 0 0 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 45. 00 60. 00 THER PATI ENT CARE SERVI CES (SPECI FY) ** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				(	0	0		
39. 00 PATIENT TRANSPORTATION** 0 0 0 0 0 0 0 39. 00 40. 00 IMAGI NG SERVI CES** 0 0 0 0 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS** 0 0 0 0 0 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 4,847 4,847 0 4,847 42. 00 43. 00 OUTPATI ENT SERVI CES** 0 0 0 0 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVI CES (SPECI FY)** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			١	(	0 0	0		
40.00   IMAGI NG SERVI CES**   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	(	0 0	0		
41. 00 LABS & DI AGNOSTI CS**  0 0 0 0 0 0 0 0 41. 00  42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE**  0 4, 847 4, 847 0 4, 847 42. 00  43. 00 OUTPATI ENT SERVI CES**  0 0 0 0 0 0 0 0 0 43. 00  44. 00 PALLI ATI VE RADI ATI ON THERAPY**  0 0 0 0 0 0 0 0 0 44. 00  45. 00 PALLI ATI VE CHEMOTHERAPY**  0 0 0 0 0 0 0 0 0 46. 00  60. 00 DITHER PATI ENT CARE SERVI CES (SPECI FY) **  NONREI MBURSABLE COST CENTERS  60. 00 BEREAVEMENT PROGRAM *  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	(	0 0	0		
42. 00       MEDI CAL SUPPLI ES-NON-ROUTI NE**       0       4,847       4,847       0       4,847       42. 00         43. 00       OUTPATI ENT SERVI CES**       0       0       0       0       0       43. 00         44. 00       PALLI ATI VE RADI ATI ON THERAPY**       0       0       0       0       0       44. 00         45. 00       PALLI ATI VE CHEMOTHERAPY**       0       0       0       0       0       0       45. 00         46. 00       OTHER PATI ENT CARE SERVICES (SPECI FY)**       0       0       0       0       0       0       0       46. 00         NONREI MBURSABLE COST CENTERS       ONDERI MERCAMENT PROGRAM *       0       0       0       0       0       0       0       60. 00         61. 00       VOLUNTEER PROGRAM *       0       0       0       0       0       0       0       61. 00         62. 00       FUNDRAI SI NG*       0       0       0       0       0       0       0       62. 00         63. 00       HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS*       0       0       0       0       0       0       0       0       0       0       0       0       0 <t< td=""><td>40. 00</td><td></td><td>0</td><td>(</td><td>0</td><td>0</td><td>0</td><td>40. 00</td></t<>	40. 00		0	(	0	0	0	40. 00
43. 00   OUTPATIENT SERVICES**   0   0   0   0   0   43. 00   44. 00   PALLIATIVE RADIATION THERAPY**   0   0   0   0   0   44. 00   45. 00   PALLIATIVE CHEMOTHERAPY**   0   0   0   0   0   0   46. 00   OTHER PATIENT CARE SERVICES (SPECIFY)**   0   0   0   0   0   46. 00   OTHER PATIENT CARE SERVICES (SPECIFY)**   0   0   0   0   0   46. 00   OTHER PATIENT CARE SERVICES (SPECIFY)**   0   0   0   0   0   46. 00   OTHER PATIENT PROGRAM *   0   0   0   0   0   46. 00   OTHER PROGRAM *   0   0   0   0   0   46. 00   OTHER PROGRAM *   0   0   0   0   46. 00   OTHER PROGRAM *   0   0   0   0   46. 00   OTHER PROGRAM *   0   0   0   46. 00   OTHER PHYSICIAN SERVICES*   0   0   0   46. 00   OTHER PHYSICIAN SERVICES*   0   0   0   46. 00   OTHER PHYSICIAN SERVICES*   0   0   0   47. 00   OTHER PHYSICIAN SERVICES*   0   0   0   48. 00   TELEHEALTH/TELEMONITORING*   0   0   0   49. 00   0   0   0   49. 00   0   0   40. 00   0   0   40. 00   0   0   40. 00   0   0   40. 00   0   0   40. 00   0   0   40. 00   0   0   41. 00   0   40. 00   0   0   40. 00   0   40. 00   0   0   40. 00   0   40. 00   0   40. 00   0   40. 00   0   40. 00   0   40. 00   0   40. 00   40. 00   0   40. 00   40	41. 00	LABS & DIAGNOSTICS**	0	(	0	0	0	41.00
44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 45. 00  46. 00 OTHER PATIENT CARE SERVI CES (SPECI FY)** 0 0 0 0 0 0 0 0 0 0 46. 00  NONREI MBURSABLE COST CENTERS  60. 00 BEREAVEMENT PROGRAM * 0 0 0 0 0 0 0 61. 00 61. 00 VOLUNTEER PROGRAM * 0 0 0 0 0 0 66. 00 62. 00 FUNDRAI SI NG* 0 0 0 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 0 66. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 68. 00 68. 00 TELEHEALTH/TELEMONI TORI NG*	42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	4, 84	7 4, 847	0	4, 847	42. 00
45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 45. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY)** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	43.00	OUTPATIENT SERVICES**	0	(	0 0	0	0	43. 00
46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	44.00	PALLIATIVE RADIATION THERAPY**	0	(	0	0	0	44. 00
NONREI MBURSABLE COST CENTERS	45.00	PALLIATIVE CHEMOTHERAPY**	0	(	0	0	0	45. 00
60. 00       BEREAVEMENT PROGRAM *       0       0       0       0       0       0       60. 00         61. 00       VOLUNTEER PROGRAM *       0       0       0       0       0       0       61. 00         62. 00       FUNDRAI SI NG*       0       0       0       0       0       62. 00         63. 00       HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS*       0       0       0       0       0       63. 00         64. 00       PALLI ATI VE CARE PROGRAM*       0       0       0       0       0       64. 00         65. 00       OTHER PHYSI CI AN SERVI CES*       0       0       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       0       0       67. 00         68. 00       TELEHEALTH/TELEMONI TORI NG*       0       0       0       0       0       68. 00	46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	(	0	0	0	46.00
61. 00		NONREI MBURSABLE COST CENTERS						1
62. 00	60.00	BEREAVEMENT PROGRAM *	0	(	0 0	0	0	60.00
63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 63. 00 64. 00 65. 00 0 0 0 0 0 64. 00 65. 00 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 0 68. 00 0 0 0 0 68. 00	61.00	VOLUNTEER PROGRAM *	o	(	ol c	0	0	61.00
63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 63. 00 64. 00 65. 00 0 0 0 0 0 64. 00 65. 00 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 0 68. 00 0 0 0 0 68. 00	62.00	FUNDRAI SI NG*	0	(	ol c	0	0	62.00
65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 65. 00 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 68. 00 0 0 0 68. 00	63.00		o	(	ol c	o	0	63.00
65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 65. 00 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 68. 00 0 0 0 68. 00	64.00	PALLIATIVE CARE PROGRAM*	o	(	ol d	o	0	64.00
66. 00 RESI DENTI AL CARE* 0 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 0 68. 00	65.00		o	(	ol d	0	0	65.00
67. 00   ADVERTI SI NG*			0	(	ol d	0		1
68. 00   TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 0 68. 00			0	(		0		
			0	(		0		
	69. 00	THRIFT STORE*	ا	·	ol o	n	0	
70. 00   NURSI NG FACI LI TY ROOM & BOARD* 0 0 0 0 70. 00			ا	·	ol o	n		1
71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 0 0 0 0 71. 00			ا	·		n	-	1
100. 00 TOTAL 0 4, 847 4, 847 164 5, 011 100. 00		, ,	ا	4 84	7 4 847	164	-	
* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.			Lumn 1 line as		.,,,,,,		2,011	

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Peri od: From 10/01/2016 To 09/30/2017 Date/Time Prepared: 2/26/2018 10:28 am Hospi ce CCN: 15-1548 Hosni ce I

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6. 00	7. 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	1	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	l .	3. 00
4.00	ADMINISTRATIVE & GENERAL*	0	0		4. 00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	l .	5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	0	1	6. 00
7.00	HOUSEKEEPI NG*	0	0		7. 00
8.00	DI ETARY*	0	0	1	8. 00
9.00	NURSING ADMINISTRATION*	0	0	1	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES*	0	0		10. 00
11. 00	MEDI CAL RECORDS*	0	0		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	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	l .	15. 00
16. 00	OTHER GENERAL SERVICE*	0	0		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25. 00	INPATIENT CARE-CONTRACTED**	0	_	i e	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	121		28. 00
29. 00	LPN/LVN**	0	0	•	29. 00
30. 00	PHYSI CAL THERAPY**	0	0	•	30. 00
31. 00	OCCUPATI ONAL THERAPY**	0	0		31. 00
32. 00	SPEECH/LANGUAGE PATHOLOGY**	0	0	i e	32. 00
33. 00	MEDICAL SOCIAL SERVICES**	0	43	1	33. 00
34. 00	SPI RI TUAL COUNSELI NG**	0	0	1	34.00
35. 00	DI ETARY COUNSELI NG**	0	0		35. 00
36. 00	COUNSELING - OTHER**	0	0	l .	36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0	1	37. 00
38. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	0	1	38. 00
39. 00	PATIENT TRANSPORTATION**	0	0	l .	39. 00
40. 00	I MAGING SERVI CES**	0	0	l .	40.00
41.00	LABS & DI AGNOSTI CS**	0	0		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	4, 847		42.00
43.00	OUTPATIENT SERVICES**	0	0	•	43.00
44. 00	PALLIATIVE RADIATION THERAPY**	0	0	•	44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**	0	0	1	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46. 00
(0.00	NONREI MBURSABLE COST CENTERS			·	
60.00	BEREAVEMENT PROGRAM *	0	_	•	60.00
61.00	VOLUNTEER PROGRAM *	0	0	1	61.00
62.00	FUNDRALSING*	0	0	i e	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	i e	63. 00
64. 00 65. 00	PALLIATIVE CARE PROGRAM*   OTHER PHYSICIAN SERVICES*	0	0	l .	64. 00 65. 00
		0	0	i e	
66. 00 67. 00	RESI DENTI AL CARE* ADVERTI SI NG*		0	i e	66. 00 67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*		0	l .	
69.00	THRIFT STORE*		0	•	68. 00 69. 00
70.00	NURSING FACILITY ROOM & BOARD*		0	i e	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)*		0	1	70.00
100.00		0	_	l .	100.00
100.00	I TO TALL		3,011		1100.00

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

CARE

Provider CCN: 15-0064

Peri od: From 10/01/2016 To 09/30/2017 Worksheet 0-2

Date/Time Prepared: 2/26/2018 10:28 am Hospi ce CCN: 15-1548

SALARI ES						Hospi ce I		
1.00   2.00   3.00   4.00   5.00			SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
DIRECT PATIENT CARE SERVICE COST CENTERS   25.00   INPATIENT CARE_CONTRACTED   25.00   26.00   PHYSI CI AN SERVICES   0 0 0 0 0 0 0 0 26.00   27.00   NURSE PRACTITIONER   0 0 0 0 0 0 0 0 27.00   28.00   REGISTERED NURSE   0 0 0 0 0 0 0 0 0 0 0 27.00   29.00					1 + col . 2)	CATI ONS		
25. 00   INPATIENT CARE-CONTRACTED     25. 00   26. 00   26. 00   26. 00   27. 00   27. 00   27. 00   28. 00   28. 00   28. 00   29. 00   27. 00   28. 00   29. 00			1.00	2.00	3. 00	4. 00	5. 00	
26. 00         PHYSI CI AN SERVI CES         0         0         0         0         0         26. 00           27. 00         NURSE PRACTITIONER         0         0         0         0         0         27. 00           28. 00         REGISTERED NURSE         0         0         0         0         121         121         28. 00           29. 00         LPN/LVN         0         0         0         0         0         29. 00           30. 00         PHYSI CAL THERAPY         0         0         0         0         0         30. 00           31. 00         OCCUPATI ONAL THERAPY         0         0         0         0         0         0         30. 00           32. 00         SPEECH/LANGUAGE PATHOLOGY         0         0         0         0         0         31. 00           33. 00         MEDI CAL SOCI AL SERVI CES         0         0         0         0         43         43         33. 00           34. 00         SPI RI TUAL COUNSELI NG         0         0         0         0         0         34. 00           35. 00         DI ETARY COUNSELI NG         0         0         0         0         0         0		DIRECT PATIENT CARE SERVICE COST CENTERS						
27. 00         NURSE PRACTITIONER         0         0         0         27. 00           28. 00         REGISTERED NURSE         0         0         0         121         121         28. 00           29. 00         LPN/LVN         0         0         0         0         0         0         29. 00           30. 00         PHYSI CAL THERAPY         0         0         0         0         0         0         30. 00           31. 00         OCCUPATI ONAL THERAPY         0         0         0         0         0         0         31. 00         0         0         0         0         31. 00         0         0         0         0         0         0         0         31. 00         0 <td>25. 00</td> <td>INPATIENT CARE-CONTRACTED</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>25. 00</td>	25. 00	INPATIENT CARE-CONTRACTED						25. 00
28. 00       REGI STERED NURSE       0       0       0       121       121       28. 00         29. 00       LPN/LVN       0       0       0       0       0       29. 00         30. 00       PHYSI CAL THERAPY       0       0       0       0       0       30. 00         31. 00       OCCUPATI ONAL THERAPY       0       0       0       0       0       0       31. 00         32. 00       SPEECH/LANGUAGE PATHOLOGY       0       0       0       0       0       0       31. 00         33. 00       MEDI CAL SOCI AL SERVI CES       0       0       0       0       0       33. 00         34. 00       SPI RI TUAL COUNSELI NG       0       0       0       0       43       43       33. 00         35. 00       DI ETARY COUNSELI NG       0       0       0       0       0       0       34. 00         36. 00       COUNSELI NG - OTHER       0       0       0       0       0       0       0       36. 00         37. 00       HOSPI CE AI DE & HOMEMAKER SERVI CES       0       0       0       0       0       0       0       0       0       38. 00 <tr< td=""><td>26. 00</td><td>PHYSI CI AN SERVI CES</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>26. 00</td></tr<>	26. 00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
29.00         LPN/LVN         0         0         0         0         29.00           30.00         PHYSI CAL THERAPY         0         0         0         0         0         30.00           31.00         OCCUPATI ONAL THERAPY         0         0         0         0         0         0         31.00           32.00         SPEECH/LANGUAGE PATHOLOGY         0         0         0         0         0         0         32.00           33.00         MEDI CAL SCI AL SERVI CES         0         0         0         0         43         43         33.00           34.00         SPI RI TUAL COUNSELI NG         0         0         0         0         0         0         0         34.00           35.00         DI ETARY COUNSELI NG         0         0         0         0         0         0         35.00           36.00         COUNSELI NG - OTHER         0         0         0         0         0         0         0         36.00           37.00         HOSPI CE AI DE & HOMEMAKER SERVI CES         0         0         0         0         0         0         0         0         0         0         0         0         0<	27. 00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
30.00   PHYSI CAL THERAPY   0 0 0 0 0 0 0 0 30.00     31.00   OCCUPATI ONAL THERAPY   0 0 0 0 0 0 0 31.00     32.00   SPEECH/LANGUAGE PATHOLOGY   0 0 0 0 0 0 0 32.00     33.00   MEDI CAL SOCI AL SERVI CES   0 0 0 0 0 0 43 43 43 33.00     34.00   SPIRI TUAL COUNSELI NG   0 0 0 0 0 0 0 34.00     35.00   DI ETARY COUNSELI NG   0 0 0 0 0 0 0 35.00     36.00   COUNSELI NG - OTHER   0 0 0 0 0 0 0 0 36.00     37.00   HOSPI CE AI DE & HOMEMAKER SERVI CES   0 0 0 0 0 0 0 0 0 37.00     38.00   DURABLE MEDI CAL EQUI PMENT/OXYGEN   0 0 0 0 0 0 0 0 0 38.00     39.00   PHYSI CAL THERAPY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00	REGI STERED NURSE	0	0	0	121	121	28. 00
31.00   OCCUPATI ONAL THERAPY   0   0   0   0   0   31.00     32.00   SPEECH/LANGUAGE PATHOLOGY   0   0   0   0   32.00     33.00   MEDI CAL SOCI AL SERVI CES   0   0   0   0   43   43   33.00     34.00   SPI RI TUAL COUNSELI NG   0   0   0   0   0   34.00     35.00   DI ETARY COUNSELI NG   0   0   0   0   0   35.00     36.00   COUNSELI NG   0   0   0   0   0   0   36.00     37.00   HOSPI CE AI DE & HOMEMAKER SERVI CES   0   0   0   0   0   37.00     38.00   DURABLE MEDI CAL EQUI PMENT/OXYGEN   0   0   0   0   0   37.00     39.00   PATI ENT TRANSPORTATI ON   0   0   0   0   0   39.00     40.00   IMAGI NG SERVI CES   0   0   0   0   0   0     41.00   LABS & DI AGNOSTI CS   0   0   0   0   0   41.00     42.00   MEDI CAL SUPPLI ES-NON-ROUTI NE   0   4,847   4,847   0   4,847   42.00	29. 00	LPN/LVN	0	0	0	0	0	29. 00
32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 0 0 0 0 43 43 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 0 0 0 0 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 0 0 0 0 0 0 35. 00 36. 00 COUNSELI NG 0 0 0 0 0 0 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 0 0 0 0 0 37. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 0 0 0 37. 00 39. 00 PATI ENT TRANSPORTATI ON 0 1 MAGI NG SERVI CES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00	PHYSI CAL THERAPY	0	0	0	0	0	30.00
33. 00       MEDI CAL SOCI AL SERVI CES       0       0       0       43       43       33. 00         34. 00       SPI RI TUAL COUNSELI NG       0       0       0       0       0       34. 00         35. 00       DI ETARY COUNSELI NG       0       0       0       0       0       0       35. 00         36. 00       COUNSELI NG - OTHER       0       0       0       0       0       0       36. 00         37. 00       HOSPI CE AI DE & HOMEMAKER SERVI CES       0       0       0       0       0       0       37. 00         38. 00       DURABLE MEDI CAL EQUI PMENT/OXYGEN       0       0       0       0       0       0       39. 00         39. 00       PATI ENT TRANSPORTATI ON       0       0       0       0       0       0       39. 00         40. 00       I MAGI NG SERVI CES       0       <	31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31. 00
34. 00       SPIRITUAL COUNSELING       0       0       0       0       34. 00         35. 00       DI ETARY COUNSELING       0       0       0       0       0       35. 00         36. 00       COUNSELING - OTHER       0       0       0       0       0       36. 00         37. 00       HOSPICE AIDE & HOMEMAKER SERVICES       0       0       0       0       0       0       37. 00         38. 00       DURABLE MEDICAL EQUI PMENT/OXYGEN       0       0       0       0       0       0       38. 00         39. 00       PATI ENT TRANSPORTATI ON       0       0       0       0       0       0       0       38. 00         40. 00       IMAGI NG SERVI CES       0	32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
35. 00 DI ETARY COUNSELI NG 0 0 0 0 0 35. 00 36. 00 COUNSELI NG - OTHER 0 0 0 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 0 0 0 0 0 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATION 0 0 0 0 0 0 38. 00 40. 00 IMAGI NG SERVI CES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33.00	MEDICAL SOCIAL SERVICES	0	0	0	43	43	33. 00
36. 00 COUNSELING - OTHER 0 0 0 0 0 0 36. 00 37. 00 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES 0 0 0 0 0 0 37. 00 38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 0 0 0 0 38. 00 39. 00 PATIENT TRANSPORTATION 0 0 0 0 0 0 0 39. 00 40. 00 IMAGING SERVICES 0 0 0 0 0 0 0 0 41. 00 LABS & DIAGNOSTICS 0 0 0 0 0 0 0 41. 00 42. 00 MEDICAL SUPPLIES-NON-ROUTINE 0 4, 847 4, 847 0 4, 847 42. 00	34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
37. 00       HOSPICE AIDE & HOMEMAKER SERVICES       0       0       0       0       37. 00         38. 00       DURABLE MEDICAL EQUIPMENT/OXYGEN       0       0       0       0       0       38. 00         39. 00       PATIENT TRANSPORTATION       0       0       0       0       0       39. 00         40. 00       IMAGING SERVICES       0       0       0       0       0       0       40. 00         41. 00       LABS & DI AGNOSTICS       0       0       0       0       0       41. 00         42. 00       MEDI CAL SUPPLI ES-NON-ROUTI NE       0       4, 847       4, 847       0       4, 847       42. 00	35.00	DI ETARY COUNSELING	0	0	0	0	0	35. 00
38. 00     DURABLE MEDI CAL EQUI PMENT/OXYGEN     0     0     0     0     38. 00       39. 00     PATI ENT TRANSPORTATI ON     0     0     0     0     0     39. 00       40. 00     I MAGI NG SERVI CES     0     0     0     0     0     0     40. 00       41. 00     LABS & DI AGNOSTI CS     0     0     0     0     0     41. 00       42. 00     MEDI CAL SUPPLI ES-NON-ROUTI NE     0     4, 847     4, 847     0     4, 847     42. 00	36.00	COUNSELING - OTHER	0	0	0	0	0	36. 00
39.00         PATIENT TRANSPORTATION         0         0         0         0         39.00           40.00         IMAGING SERVICES         0         0         0         0         0         40.00           41.00         LABS & DIAGNOSTICS         0         0         0         0         0         41.00           42.00         MEDICAL SUPPLIES-NON-ROUTINE         0         4,847         4,847         0         4,847         42.00	37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37. 00
40. 00       I MAGI NG SERVI CES       0       0       0       0       40. 00         41. 00       LABS & DI AGNOSTI CS       0       0       0       0       0       41. 00         42. 00       MEDI CAL SUPPLI ES-NON-ROUTI NE       0       4, 847       4, 847       0       4, 847       42. 00	38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
41. 00 LABS & DIAGNOSTICS 0 0 0 0 0 41. 00 42. 00 MEDICAL SUPPLIES-NON-ROUTINE 0 4, 847 4, 847 0 42. 00	39. 00	PATIENT TRANSPORTATION	0	0	0	0	0	39. 00
42. 00 MEDICAL SUPPLIES-NON-ROUTINE 0 4, 847 4, 847 0 4, 847 42. 00	40.00	I MAGING SERVICES	0	0	0	0	0	40. 00
	41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41. 00
	42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	4, 847	4, 847	0	4, 847	42. 00
43.00   OUTPATIENT SERVICES   O  O  O  O  43.00	43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 0 44. 00	44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45. 00 PALLI ATI VE CHEMOTHERAPY 0 0 0 0 0 45. 00	45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 46.00	46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46. 00
100. 00 TOTAL * 0 4, 847 4, 847 164 5, 011 100. 00	100.00	TOTAL *	0	4, 847	4, 847	164	5, 011	100. 00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5	
		7.D3 00 TIME IV TO	± col. 6)	
		6. 00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED			25. 00
26.00	PHYSI CI AN SERVI CES	0	o	26. 00
27.00	NURSE PRACTITIONER	0	o	27. 00
28. 00	REGI STERED NURSE	0	121	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	43	33. 00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	39. 00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	4, 847	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
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	5, 011	100. 00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM			workshoot O E	
COST ALLOCATION - DETERMINATION OF HOSPITAL-E EXPENSES FOR ALLOCATION	BASED HUSPICE NET Provider C	CN: 15-0064	Peri od: From 10/01/2016	Worksheet 0-5	
EXPENSES FOR ALLOCATION	Hospi ce CC		To 09/30/2017		pared:
			Hospi ce I	2/20/2010 10.	20 aiii
Descriptions		HOSPICE DIREC		TOTAL EXPENSES	
·		EXPENSES (see		(sum of cols.	
		instructions	EXPENSES FROM	1 + 2)	
			WKST B PART I		
			(see		
		4.00	instructions)	0.00	
GENERAL SERVICE COST CENTERS		1.00	2. 00	3. 00	
1. 00 CAP REL COSTS-BLDG & FLXT			0 0	0	1.00
2.00 CAP REL COSTS-BEDG & TTXT			0 0		2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT			0 40	-	1
4. 00 ADMINISTRATIVE & GENERAL			0 985		
5. 00 PLANT OPERATION & MAINTENANCE			0 0		
6.00 LAUNDRY & LINEN SERVICE			0 0		
7. 00 HOUSEKEEPI NG			0 0	0	1
8. 00 DI ETARY			0 0	0	1
9.00 NURSING ADMINISTRATION			0 0	0	9. 00
10.00 ROUTINE MEDICAL SUPPLIES			0 0	0	10.00
11. 00 MEDI CAL RECORDS			0 291	291	11. 00
12.00 STAFF TRANSPORTATION			0	0	12. 00
13.00 VOLUNTEER SERVICE COORDINATION			0	0	13. 00
14.00 PHARMACY			0	-	14. 00
15. 00 PHYSICIAN ADMINISTRATIVE SERVICES			0	0	
16. 00 OTHER GENERAL SERVICE			0		16. 00
17. 00 PATIENT/RESIDENTIAL CARE SERVICES			0	0	17. 00
LEVEL OF CARE 50. 00 HOSPI CE CONTI NUOUS HOME CARE		Γ	ol	0	FO 00
50. 00 HOSPICE CONTINUOUS HOME CARE 51. 00 HOSPICE ROUTINE HOME CARE		5, 01	-	5, 011	
52. 00 HOSPICE INPATIENT RESPITE CARE		5,01	0	5,011	1
53. 00 HOSPICE THRAITENT RESPITE CARE			0	0	
NONREI MBURSABLE COST CENTERS		1	0	0	33.00
60. 00 BEREAVEMENT PROGRAM			0	0	60.00
61. 00 VOLUNTEER PROGRAM			0	0	61. 00
62. 00 FUNDRAI SI NG			O	l o	62. 00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	1
64.00 PALLIATIVE CARE PROGRAM			0	0	64. 00
65. 00 OTHER PHYSICIAN SERVICES			0	0	65. 00
66. 00 RESI DENTI AL CARE			0	0	66. 00
67. 00 ADVERTI SI NG			0	0	
68 OO TELEHEALTH/TELEMONLTOPING		1	Ol.	1	60 00

0 68. 00

0 71.00 99. 00

1, 316

6, 327 100. 00

69. 00 70. 00 0 0

100. 00 TOTAL

68. 00 | TELEHEALTH/TELEMONI TORI NG

69. 00 THRIFT STORE
70. 00 NURSING FACILITY ROOM & BOARD

71. 00 OTHER NONREIMBURSABLE (SPECIFY)
99. 00 NEGATIVE COST CENTER

Heal th	Financial Systems	FAYETTE REGIONAL HI	EALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider CCN: 15-0064		Peri od:	Worksheet 0-6	
					From 10/01/2016	Part I	
			Hospi ce CCI	N: 15-1548	To 09/30/2017	Date/Time Pre	pared:
						2/26/2018 10:	28 am_
					Hospi ce I		
	Descriptions	TOTAL EXPENSES CA				SUBTOTAL	
			FIX	EQUI P	BENEFITS		
					DEPARTMENT		
		0	1. 00	2. 00	3. 00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	0	0				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0		2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	40	0		0 40		3. 00
4.00	ADMINISTRATIVE & GENERAL	985	0		0 0	985	4. 00
5.00	PLANT OPERATION & MAINTENANCE	o	0		0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE	ol	0		0 0	0	6. 00
7.00	HOUSEKEEPI NG	l ol	0		0 0	0	7. 00
8.00	DI ETARY	l ol	0		0 0	0	8.00
9. 00	NURSING ADMINISTRATION	ام	0		0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES		0		0 0	0	
11. 00	MEDI CAL RECORDS	291	0		0	291	11. 00
12. 00	STAFF TRANSPORTATION	270	0		0	0	1
13. 00	VOLUNTEER SERVICE COORDINATION		0		0	0	
14. 00	PHARMACY		0		0	0	
			0		0	0	
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0	_	
16.00	OTHER GENERAL SERVICE	٩	0		0 0	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		0		0	0	17. 00
	LEVEL OF CARE			T	_	_	
50. 00	HOSPICE CONTINUOUS HOME CARE	0			0	0	
51. 00	HOSPICE ROUTINE HOME CARE	5, 011			40	5, 051	
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0	0	
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0		0 0	0	53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0	0	60. 00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	61.00
62.00	FUNDRAI SI NG	o	0		0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	o	0		0 0	0	64. 00
65.00	OTHER PHYSICIAN SERVICES	l ol	0		0 0	0	65. 00
66. 00	RESI DENTI AL CARE	l ol	0		0 0	0	66. 00
67. 00	ADVERTI SI NG	l ol	0		0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG		0		0 0	0	68. 00
69. 00	THRI FT STORE		0		0 0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD		O			0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)		0		0	0	71.00
99. 00	NEGATIVE COST CENTER		0		0 0	U	99.00
	TOTAL	6, 327	0		0 40	6 227	100.00
100.00	// TOTAL	0,327	0	I	O <sub>1</sub> 40	0, 327	1100.00

near tri	Financiai systems	ATELLE REGIONAL	HEALIH STOLEN	l		eu or Form CWS	3-2332-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provi der C	CN: 15-0064	Peri od:	Worksheet 0	-6
				N. 15 1540	From 10/01/201	6 Part I	
			Hospi ce CC	N: 15-1548	To 09/30/201	7 Date/Time Pr 2/26/2018 10	reparea:
					Hospi ce I	2/20/2010 10	U. 20 alli
	Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	
	besci i pti ons	& GENERAL	OPERATION &	LINEN SERVICE		DILIANI	
		& GLINLKAL	MAI NTENANCE	LINEN SERVIC	,L		
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
1.00	CAP REL COSTS-BLDG & FLXT						1, 00
2. 00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00	ADMINISTRATIVE & GENERAL	985					4.00
5.00	PLANT OPERATION & MAINTENANCE	965	_				5.00
					0		
6.00	LAUNDRY & LINEN SERVICE	0	C	(	U		6.00
7.00	HOUSEKEEPI NG	0	C				7. 00
8.00	DI ETARY	0	C				0 8.00
9.00	NURSI NG ADMI NI STRATI ON	0	C	2		0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	C	)		0	10.00
11. 00	MEDI CAL RECORDS	54	C	)		이	11. 00
12. 00	STAFF TRANSPORTATION	0	C	)		이	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	0	C	)		이	13. 00
14. 00	PHARMACY	0	C			이	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	C			0	15. 00
16. 00	OTHER GENERAL SERVICE	0	C	1		0	16. 00
17. 00		0	C	)		0	17. 00
	LEVEL OF CARE					_	
50. 00	HOSPICE CONTINUOUS HOME CARE	0					50. 00
51. 00	HOSPICE ROUTINE HOME CARE	931					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
	NONREI MBURSABLE COST CENTERS					_	
60.00	BEREAVEMENT PROGRAM	0	C	)		0	60. 00
61.00	VOLUNTEER PROGRAM	0	C	)		0	61. 00
62.00	FUNDRAI SI NG	0	C	)		0	62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	C			0	63. 00
64.00	PALLIATIVE CARE PROGRAM	0	C			0	64. 00
65.00	OTHER PHYSICIAN SERVICES	0	C			o	65. 00
66.00	RESI DENTI AL CARE	0	C		0	o	0 66.00
67.00	ADVERTI SI NG	0	C			o	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0	C			o	68. 00
69.00	THRI FT STORE	0	C			o	69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71. 00			C		0	ol	0 71.00
	NEGATIVE COST CENTER	0	C		О	ol	0 99.00
	TOTAL	985	C	ol	Ö	o	0 100.00
				•		•	

Heal th Financial	Systems		FAYETTE REGIONAL	. HEALT	H SYS	TEM		In Lieu o	f Form CM	/IS-2552-1	0
COOT ALLOCATION	HOODITAL BACED	HOODLOE OFNEDAL	OFFILL OF COOTS			0.011 45 0044	- · ·	1.01			_

Heal th	Financial Systems	FAYETTE REGIONAL H	IEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provi der CC	CN: 15-0064	Peri od:	Worksheet 0-6	
					From 10/01/2016	Part I	
			Hospi ce CCN	N: 15-1548	To 09/30/2017	Date/Time Pre	
					Hooni oo I	2/26/2018 10:	28 am
	Decemintiana	MURCLNC	DOUTI NE	MEDICAL	Hospi ce I	VOLUNTEED	
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
		ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATI ON	SERVI CE	
		9.00	SUPPLIES 10.00	11. 00	12.00	COORDI NATI ON 13. 00	
	GENERAL SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-BEDG & TTXT						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
	1						
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON	O O					9.00
10.00	ROUTINE MEDICAL SUPPLIES	O O	0				10.00
11.00	MEDI CAL RECORDS	O O		3	45		11.00
12. 00	STAFF TRANSPORTATION	O			0	_	12.00
13. 00	VOLUNTEER SERVICE COORDINATION	O			0	0	
14. 00	PHARMACY	0			0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	O			0	0	15. 00
16. 00	OTHER GENERAL SERVICE	0			0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						
50. 00	HOSPICE CONTINUOUS HOME CARE	0	0		0	0	
51. 00	HOSPICE ROUTINE HOME CARE	0	0	3	45 0	0	
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
	NONREI MBURSABLE COST CENTERS						
60. 00	BEREAVEMENT PROGRAM	0			0	0	
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	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	THRIFT STORE	0			0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	O			0	0	71. 00
99.00	NEGATIVE COST CENTER	0	o		0 0	0	99. 00
100.00	TOTAL	0	0	3	45 0	0	100. 00
		•					

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15-0064 Peri od: Worksheet 0-6 From 10/01/2016 Part I Hospi ce CCN: 15-1548 09/30/2017 Date/Time Prepared: To 2/26/2018 10:28 am Hospi ce I PHARMACY PHYSI CI AN OTHER GENERAL PATI ENT/ TOTAL Descriptions ADMI NI STRATI VE SERVI CE RESI DENTI AL SERVI CES CARE SERVICES 14. 00 16. 00 18.00 15.00 17.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 ADMINISTRATIVE & GENERAL 5.00 PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE 6.00 7.00 HOUSEKEEPI NG 8.00 DI ETARY NURSING ADMINISTRATION 9.00 ROUTINE MEDICAL SUPPLIES 10.00 11.00 MEDICAL RECORDS 12.00 STAFF TRANSPORTATION

Health Financial Systems	FAYETTE REGIONAL HE	ALTH SYSTEM	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL STATISTICAL BASIS		Provider CCN: 1 Hospice CCN:	From 10/01/2016	Worksheet 0-6 Part II Date/Time Prepared:

			Hospi ce cci	: 15-1548   1	0 09/30/2017	2/26/2018 10:	
					Hospi ce I	2,20,2010 101	20 4
	Cost Center Descriptions	CAP REL BLDG & CA	AP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
	'	FLX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (D	OLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
				(GROSS		COSTS)	
				SALARI ES)		ŕ	
		1.00	2.00	3. 00	4A	4. 00	
·	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	0					1. 00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1			3. 00
4.00	ADMINISTRATIVE & GENERAL	0	0	(	-985	5, 342	4. 00
5.00	PLANT OPERATION & MAINTENANCE	0	0	(	0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0	(	0	0	6. 00
7.00	HOUSEKEEPING	0	0	(	0	0	7. 00
8.00	DI ETARY	0	0	(	0	0	8. 00
9.00	NURSING ADMINISTRATION	0	0	(	0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	(	0	0	10.00
11. 00	MEDI CAL RECORDS	0	0	(	0	291	11. 00
12.00	STAFF TRANSPORTATION	0	0	(	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	(	0	0	13.00
14.00	PHARMACY	0	0	(	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	o	0	(	0	0	15. 00
16.00	OTHER GENERAL SERVICE	o	0	(	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			(	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			1	0	5, 051	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	o	O	(	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	o	O	(	0	0	53.00
	NONREI MBURSABLE COST CENTERS	·					
60.00	BEREAVEMENT PROGRAM	0	0	(	0	0	60.00
61.00	VOLUNTEER PROGRAM	o	o	(	0	0	61.00
62.00	FUNDRAI SI NG	o	o	(	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o	o	(	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	o	O	(	0	0	64. 00
65.00	OTHER PHYSICIAN SERVICES	o	O	(	0	0	65.00
66.00	RESI DENTI AL CARE	o	0	(	0	0	66. 00
67.00	ADVERTI SI NG	o	0	(	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	o	0	(	0	0	68. 00
69. 00	THRIFT STORE	O	0	(	0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD				0		70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	O	(	0	0	71. 00
99. 00	NEGATIVE COST CENTER						99. 00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	40		985	100.00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	40. 000000	)	0. 184388	101. 00

Health Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provi der Co		Peri od:	Worksheet 0-6	
STATISTICAL BASIS		Hospi ce CCI		From 10/01/2016 To 09/30/2017	Part II   Date/Time Pre	nared:
		nospi ce ooi	13 1340	10 07/30/2017	2/26/2018 10:	28 am
				Hospi ce I		
Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	NURSI NG	
	OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMI NI STRATI ON	
	MAI NTENANCE	(IN-FACILITY		DAYS)		
	(SQUARE FEET)	DAYS)			(DI RECT NURS.	
					HRS. )	
	E 00	4 00	7 00	0 00	0.00	

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)		DAYS)	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	
	I	5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	T		T			
1.00	CAP REL COSTS-BLDG & FLXT	4					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	HOUSEKEEPI NG	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
	MEDI CAL RECORDS	0		0		0	11. 00
	STAFF TRANSPORTATION	0		0		0	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	0		0		0	13. 00
	PHARMACY	0		0		0	14. 00
	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15. 00
	OTHER GENERAL SERVICE	0		0		0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17. 00
	LEVEL OF CARE	1	1	1			
	HOSPICE CONTINUOUS HOME CARE					0	50. 00
	HOSPICE ROUTINE HOME CARE	_	_	_	_	0	51. 00
	HOSPICE INPATIENT RESPITE CARE	0			0		52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREI MBURSABLE COST CENTERS	1 _		_		_	
	BEREAVEMENT PROGRAM	0	ŀ	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61. 00
	FUNDRAL SI NG	0		0		0	62.00
	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63. 00
	PALLIATIVE CARE PROGRAM	0		0		0	64.00
	OTHER PHYSI CI AN SERVI CES	0		0		0	65. 00
	RESI DENTI AL CARE	0	0	0	0	0	66. 00
	ADVERTI SI NG	0		0		0	67. 00
		0					68. 00
69. 00	THRIFT STORE	0		0		0	69. 00
	NURSING FACILITY ROOM & BOARD		_		•		70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0		1	Ü	0	71. 00
	NEGATIVE COST CENTER		_		•		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0 000000	0 000000	0 000000	0 000000	1	100.00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.000000	0. 000000	0.000000	101.00

Health Financial Systems	FAYETTE REGIONAL HI	EALTH SYSTEM	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERA STATISTICAL BASIS	L SERVICE COSTS	Provider CCN: Hospice CCN:	Peri od: From 10/01/2016 To 09/30/2017	Worksheet 0-6 Part II Date/Time Prepared:

31/1113	TIONE BROTO		Hospi ce CCI	N: 15-1548	To	09/30/2017	Date/Time Pro 2/26/2018 10:	
						Hospi ce I		
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATI (MI LEAGE)	ON	VOLUNTEER 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		10.00	11.00	
1.00	CAP REL COSTS-BLDG & FLXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3. 00
4.00	ADMINISTRATIVE & GENERAL							4.00
5.00	PLANT OPERATION & MAINTENANCE							5. 00
6.00	LAUNDRY & LINEN SERVICE							6. 00
7.00	HOUSEKEEPI NG							7. 00
8.00	DI ETARY							8. 00
9.00	NURSING ADMINISTRATION							9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0						10.00
11.00	MEDICAL RECORDS		36	,				11. 00
12.00	STAFF TRANSPORTATION				0			12. 00
13.00	VOLUNTEER SERVICE COORDINATION				0	o		13. 00
14.00	PHARMACY				0	o	C	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES				0	o	C	15. 00
16.00	OTHER GENERAL SERVICE				0	o	C	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES							17. 00
	LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0		l .	0	0	C	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	36	,	0	0	C	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	1	0	0	C	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0	0		53.00
	NONREI MBURSABLE COST CENTERS			,				
60. 00	BEREAVEMENT PROGRAM				0	0	C	
61. 00	VOLUNTEER PROGRAM				0	0	C	
62. 00	FUNDRAI SI NG				0	0	C	02.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0	0	C	
64. 00	PALLIATIVE CARE PROGRAM				0	0	C	
65. 00	OTHER PHYSICIAN SERVICES				0	0	C	
66.00	RESI DENTI AL CARE				0	0	C	1 00.00
67. 00	ADVERTI SI NG				0	0	C	, , , , , ,
68. 00	TELEHEALTH/TELEMONI TORI NG				0	0	C	
69. 00	THRIFT STORE				U	U	C	69.00
70.00	NURSING FACILITY ROOM & BOARD				_			70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)				U	0	C	
	NEGATIVE COST CENTER		245		0		-	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I) UNIT COST MULTIPLIER	0. 000000	345 9. 583333		OO	0. 000000	0. 000000	
101.00	IONII COSI WOLIIPLIEK	0.000000	7. 003333	0.0000	UU	0. 000000	0.000000	71101.00

Health Financial Systems	FAYETTE REGIONAL HE	ALTH SYSTEM		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL STATISTICAL BASIS	SERVICE COSTS	Provider CCN:		Peri od: From 10/01/2016	Worksheet 0-6 Part II
STATISTICALE BASIS		Hospice CCN:	15-1548	To 09/30/2017	Date/Time Prepared:

			nospi ce cc	N. 13-1340	10 07/30/2017	2/26/2018 10:	
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI VE		RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICES	S		
		(PATIENT DAYS)	BASIS)	(IN-FACILITY			
		(171112111 27110)	5/10/0)	DAYS)			
		15. 00	16. 00	17. 00			
	GENERAL SERVICE COST CENTERS	10.00	10.00	17.00			
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
	1						
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9. 00	NURSI NG ADMINI STRATI ON						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES						10. 00
11. 00	MEDI CAL 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	0					15. 00
16.00	OTHER GENERAL SERVICE		C				16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE			•			
50.00	HOSPICE CONTINUOUS HOME CARE	0	C				50.00
51.00	HOSPICE ROUTINE HOME CARE	0	l c				51.00
	HOSPICE INPATIENT RESPITE CARE	0	ł		0		52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	0	<b>l</b>		0		53. 00
00.00	NONREI MBURSABLE COST CENTERS			1			1 00.00
60.00	BEREAVEMENT PROGRAM		C	)			60.00
61. 00	VOLUNTEER PROGRAM		ĺ				61. 00
62. 00	FUNDRAI SI NG		Ĭ	1			62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		Č	1			63.00
	PALLIATIVE CARE PROGRAM			1			64. 00
65. 00	OTHER PHYSICIAN SERVICES						65. 00
	1	0			0		
	RESI DENTI AL CARE	0			U		66.00
67. 00	ADVERTI SI NG						67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG			()			68. 00
	THRIFT STORE			ή			69. 00
70. 00	NURSING FACILITY ROOM & BOARD						70. 00
	OTHER NONREIMBURSABLE (SPECIFY)	0	C	)	0		71. 00
	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		[ C	)	0		100. 00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.00000	00		101. 00

	Financial Systems TONMENT OF HOSPITAL-BASED HOSPICE SHARED SI	FAYETTE REGIONAL	Provider CC	N: 15_0064	Peri od:	u of Form CMS-2 Worksheet 0-7	
	OF CARE	INVICE COSTS BI			From 10/01/2016		
			Hospi ce CCN	l: 15-1548	To 09/30/2017	Date/Time Pre 2/26/2018 10:	pared: 28 am
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C,		HCHC	HRHC	HI RC	
		Part I, Col. 9	Ratio				
		line 0	1.00	2. 00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS	0 1	1.00	2.00	3.00	4.00	
1.00	PHYSI CAL THERAPY	66. 00	0. 595193		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. 333526		0	0	
5.00	DURABLE MEDICAL EQUIP-RENTED	96. 00				_	5. 00
6. 00	LABORATORY	60.00	0. 186643		0 0	0	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0. 490042		0 0	0	
8. 00 8. 01	CLINIC BIC	93. 00 93. 01	0. 787460 8. 124288		0 0	0	
8. 05	PODI ATRY	93. 05	0. 014925			0	
9. 00	RADI OLOGY-THERAPEUTI C	55. 00	0.014725			O	9.00
10.00		76. 00					10.00
11.00	Totals (sum of lines 1-11)						11. 00
		Charges by LOC		Shared Servi	ce Costs by LOC		
		(from Provider					
	Cost Center Descriptions	Records) HGIP	UCUC (col. 1 v	UDUC (asl 1	xHIRC (col. 1 x	UCLD (asl 1 v	
	Cost Center Descriptions	погр	col. 2)	col. 3)	col. 4)	col. 5)	
		5.00	6.00	7. 00	8. 00	9. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	0	0		0 0	0	
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY		0		0	0	3.00
4. 00 5. 00	DRUGS CHARGED TO PATIENTS DURABLE MEDICAL EQUIP-RENTED	١	0		0 0	0	4. 00 5. 00
6. 00	LABORATORY		0		0	0	
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0 0	0	
8. 00	CLINIC		o		0	0	
8. 01	BIC	O	o		0 0	0	1
8. 05	PODI ATRY	0	o		0 0	0	8. 05
0 00	DADI OLOCY THEDADELITI C	1					0 00

9. 00 10. 00 0 11. 00

9. 00 RADI OLOGY-THERAPEUTI C
10. 00 OTHER ANCI LLARY SERVI CE COST CENTERS

11.00 Totals (sum of lines 1-11)

Health Financial Systems	FAYETTE REGIONAL H	EALTH SYSTEM	In Lie	eu of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE P	R DIEM COST	Provi der CCN: 15-0064	Peri od: From 10/01/2016	Worksheet 0-8
		Hospice CCN: 15-1548		Date/Time Prepared:

		nospi ce cci	1. 15-1546 1	0 09/30/201/	2/26/2018 10:	
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1. 00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7	7, col. 6,			0	1. 00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2. 00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3. 00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	9 10)	C	0		4. 00
5.00	Program cost (line 3 times line 4)			0		5. 00
	HOSPICE ROUTINE HOME CARE			, ,		
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	7, col. 7,			6, 327	6. 00
	line 11)					
7. 00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				36	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				175. 75	1
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 11)	C	0		9. 00
10. 00	Program cost (line 8 times line 9)			0		10.00
	HOSPICE INPATIENT RESPITE CARE					
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7	7, col. 8,			0	11. 00
	line 11)				_	
12. 00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				0	1
13. 00	Total average cost per diem (line 11 divided by line 12)				0. 00	13. 00
14. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 12)	C	0		14. 00
15. 00	Program cost (line 13 times line 14)			0		15. 00
	HOSPICE GENERAL INPATIENT CARE					
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7	7, col. 9,			0	16. 00
	line 11)				_	
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				0	1
18. 00	Total average cost per diem (line 16 divided by line 17)				0.00	18. 00
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 13)	C	0		19. 00
20. 00	Program cost (line 18 times line 19)			0		20. 00
	TOTAL HOSPICE CARE					
	Total cost (sum of line 1 + line 6 + line 11 + line 16)				6, 327	1
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				36	
23. 00	Average cost per diem (line 21 divided by line 22)				175. 75	23.00

Heal th	Financial Systems FAYETTE REGIONAL H	IFALTH SYSTEM	Inlie	u of Form CMS-2	2552_10		
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0064	Period: From 10/01/2016 To 09/30/2017	Worksheet L	pared:		
		Title XVIII	Hospi tal	PPS			
				1.00			
	PART I - FULLY PROSPECTIVE METHOD			1. 00			
	CAPITAL FEDERAL AMOUNT						
1.00	Capital DRG other than outlier			129, 530	1. 00		
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01		
2.00	Capital DRG outlier payments			1, 948	2. 00		
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01		
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	5. 68			
4. 00 5. 00	Number of interns & residents (see instructions) Indirect medical education percentage (see instructions)			0. 00 0. 00			
6. 00	Indirect medical education percentage (see instructions)	sum of lines 1 and 1 01	columns 1 and	0.00	6.00		
0.00	1.01) (see instructions)	sum of fiftes f and f. of	, corumns r and	١	0.00		
7. 00	Percentage of SSI recipient patient days to Medicare Part A p 30) (see instructions)	oatient days (Worksheet E	, part A line	0. 00	7. 00		
8.00	Percentage of Medicaid patient days to total days (see instru	uctions)		0.00	8. 00		
9.00	Sum of lines 7 and 8			0. 00			
10.00	Allowable disproportionate share percentage (see instructions	s)		0.00			
11.00	Disproportionate share adjustment (see instructions)		0	11. 00			
12. 00	Total prospective capital payments (see instructions)			131, 478	12.00		
				1. 00			
	PART II - PAYMENT UNDER REASONABLE COST						
1.00	Program inpatient routine capital cost (see instructions)			0	1. 00		
2.00	Program inpatient ancillary capital cost (see instructions)			0			
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00		
4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	4. 00 5. 00		
5.00	Total impatrent program capital cost (fine 3 x fine 4)			0	5.00		
	DADT LLL COMPUTATION OF EVOEDTION DAVISATION			1. 00			
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1. 00		
2. 00	Program inpatient capital costs (see instructions)  Program inpatient capital costs for extraordinary circumstance	res (see instructions)		0	2.00		
3. 00	Net program inpatient capital costs (line 1 minus line 2)	ces (see Thisti detrons)		Ö	3. 00		
4. 00	Applicable exception percentage (see instructions)			0.00			
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00		
6.00	Percentage adjustment for extraordinary circumstances (see ir			0.00	6. 00		
7. 00	Adjustment to capital minimum payment level for extraordinary	, circumstances (line 2 x	: line 6)	0			
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00		
9. 00 10. 00	Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to c		Loca Lino O)	0	9. 00 10. 00		
11. 00	Carryover of accumulated capital minimum payment level over of			0	11.00		
11.00	Worksheet L, Part III, line 14)	sapi tai payment (11 cm pi i	or year	Ĭ	11.00		
12.00	Net comparison of capital minimum payment level to capital pa	ayments (line 10 plus lin	ie 11)	0	12. 00		
13.00	Current year exception payment (if line 12 is positive, enter	0	13. 00				
14. 00	Carryover of accumulated capital minimum payment level over o	capital payment for the f	following period	0	14. 00		
15 00	(if line 12 is negative, enter the amount on this line)	**************************************		0	15 00		
15. 00 16. 00	Current year allowable operating and capital payment (see ins Current year operating and capital costs (see instructions)	structions)		0	15. 00 16. 00		
	Current year exception offset amount (see instructions)			0			
20	Current year exception oriset amount (see instructions)						