| Heal th Financia | al Systems | | FAYETTE REGIONAL HE | EALTH SYSTEM | | In Lieu | u of Form CMS-2552-10 |
|---|---|--|--|--|---|--|--|
| | | 42 USC 1395g; 42 | CFR 413.20(b)). Fai | lure to report can r | result in a | all interim | FORM APPROVED |
| payments made | since the beginning | g of the cost re | porting period being | deemed overpayments | s (42 USC 1 | 1395g). | OMB NO. 0938-0050 EXPIRES 05-31-2019 |
| HOSPITAL AND H AND SETTLEMENT | | E COMPLEX COST R | EPORT CERTIFICATION | Provider CCN: 15-00 | From | od: 10/01/2017 09/30/2018 | Worksheet S Parts I-III Date/Time Prepared: 2/28/2019 1:02 pm |
| PART I - COST | REPORT STATUS | | | | | | |
| Provi der | 1. [X] Electronic | ally filed cost | report | | Da | ate: 2/28/20 | 19 Time: 1:02 pm |
| use only | 2. []Manually s | | | | | | |
| | 3.[0]If this is 4.[F]Medicare U | an amended repo tilization. Ente | ort enter the number er "F" for full or "L | of times the provid " for low. | er resubmi | tted this co | ost report |
| Contractor use only | 5. [1]Cost Repor (1) As Submitte (2) Settled wit (3) Settled wit (4) Reopened (5) Amended | d 7.Cc hout Audit 8.[| te Received: ntractor No. N]Initial Report fc N]Final Report for | or this Provider CCN this Provider CCN | 12. [0]I f | ctor's Vendo Fline 5, co | or Code: 4 Iumn 1 is 4: Enter es reopened = 0-9. |
| PART II - CERT | I FI CATI ON | | | | | | |
| ADMI NI STRATI VE PROVI DED OR PR ADMI NI STRATI VE | ACTION, FINE AND/O OCURED THROUGH THE ACTION, FINES AND | DR IMPRISONMENT PAYMENT DIRECTL /OR IMPRISONMENT | ATION CONTAINED IN T UNDER FEDERAL LAW. Y OR INDIRECTLY OF A MAY RESULT. R OR ADMINISTRATOR OF | FURTHERMORE, IF SERV KICKBACK OR WERE OT | /ICES IDEN | FIFIED IN TH | IS REPORT WERE |
| | | | | | | | |
| el ectr Expens 10/01/ correc i nstru provi s | conically filed or ses prepared by FAY (2017 and ending 09 ct, complete and pr actions, except as | manually submitt ETTE REGIONAL HE /30/2018 and to epared from the noted. I furthe services, and 1 | bove certification st ed cost report and t CALTH SYSTEM (15-006 the best of my knowl books and records of er certify that I am that the services ide ts. | the Balance Sheet and 4) for the cost re- edge and belief, this the provider in acc familiar with the la | d Statemen porting pe is report a cordance w aws and re | t of Revenue riod beginni and statemer ith applicat gulations re | e and ng nt are true, ole egarding the |

[]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

Date

| | | | 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 | 72, 429 | -35, 763 | 0 | -166, 429 | 1.00 |
| 2.00 | Subprovider - IPF | 0 | 2 | 0 | | 2, 611 | 2.00 |
| 3.00 | Subprovider - IRF | 0 | 0 | 0 | | 0 | 3.00 |
| 4.00 | SUBPROVI DER I | | | | | | 4.00 |
| 5.00 | Swing bed - SNF | 0 | 0 | 0 | | 0 | 5.00 |
| 6.00 | Swing bed - NF | 0 | | | | 0 | 6.00 |
| 9.00 | HOME HEALTH AGENCY I | 0 | 0 | 0 | | 0 | 9.00 |
| 200.00 | Total | 0 | 72, 431 | -35, 763 | 0 | -163, 818 | 200.00 |

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

| | TAL AND HOSPITAL HEALTH CARE COMPLEX I | FAYETTE REGIONAL DENTIFICATION DATA | | ler CCN: 1 | | Period: From 10/01/ To 09/30/ | 2017 2018 | of For Workshe Part I Date/Ti 2/28/20 | et S-2 me Pre | 2 epared: |
|----------------|---|--|--|--|-----------|-------------------------------------|--------------|---|------------------|-------------------|
| | 1.00 | 2.00 | | 3.00 | | 4 | 1.00 | | | |
| | Hospital and Hospital Health Care Co | | | | | | | | | 4 |
| 00 | Street: 1941 VIRGINIA AVE | PO Box: | 7: - 0 | - 47001 | C | | | | | 1.0 |
| 00 | City: CONNERSVILLE | State: IN | Zip Cod CCN | e: 47331 CBSA | Provi der | y: FAYETTE | Dayma | at Cuat | om (D | 2.0 |
| | | Component Name | Number | Number | Type | Date Certified | | nt Syst 0, or | | |
| | | | Number | | Type | Continued | V 1, | | | - |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | 7.00 | | 1 |
| | Hospital and Hospital-Based Componen | t Identification: | | | | | | | - | |
| 00 | Hospi tal | FAYETTE REGIONAL HEALTH | 150064 | 99915 | 1 | 07/01/1966 | Ν | P | 0 | 3.0 |
| | | SYSTEM | | 00045 | | 10 101 10010 | | | | |
| 00 | Subprovider - IPF | FAYETTE REGIONAL HEALTH | 15S064 | 99915 | 4 | 10/01/2013 | Ν | P | 0 | 4.0 |
| 00 | Subprovider - IRF | SYSTEM FAYETTE REGIONAL HEALTH | 15T064 | 99915 | 5 | 10/01/2013 | Ν | Р | 0 | 5.0 |
| 00 | | SYSTEM | 151004 | 77713 | | 10/01/2013 | IN | | | 5.0 |
| 00 | Subprovider - (Other) | | | | | | | | | 6.0 |
| 00 | Swing Beds - SNF | FAYETTE REGIONAL HEALTH | 150064 | 99915 | | 06/25/2009 | Ν | P | Р | 7.0 |
| | _ | SYSTEM | | | | | | | | |
| 00 | Swing Beds - NF | | | | | | | | | 8. (|
| 00 | Hospital-Based SNF | | | | | | | | | 9.1 |
| 00 | | | | | | | | | | 10. |
| 00 00 | Hospi tal -Based OLTC Hospi tal -Based HHA | | | | | | | | | 11. |
| | Separately Certified ASC | | | | | | | | | 12. |
| | Hospi tal -Based Hospi ce | | | | | | | | | 14. |
| 00 | Hospital -Based Health Clinic - RHC | | | | | | | | | 15. |
| 00 | Hospital-Based Health Clinic - FQHC | | | | | | | | | 16. |
| 00 | Hospital-Based (CMHC) I | | | | | | | | | 17. |
| 00 | Renal Dialysis | | | | | | | | | 18. |
| . 00 | Other | | | | | | | | | 19. (|
| | | | | | | From: | | To | | - |
| 00 | Cost Reporting Period (mm/dd/yyyy) | | | | | 1.00 | 17 | 2.0 | | 20. (|
| | Type of Control (see instructions) | | | | | 2 | | 077 307 | 2010 | 21. (|
| | | | | | | | | | | |
| | | | | | 1.00 | 2.00 | | 3. (|)0 | |
| | Inpatient PPS Information | | | | | | | | | |
| | | currently receiving pay | ments for | - | Y | N | | | | 22. |
| 00 | | | | | 1 | | | | | |
| 00 | disproportionate share hospital adju | stment, in accordance wi | th 42 CFF | | I | | | | | |
| 00 | disproportionate share hospital adju §412.106? In column 1, enter "Y" fo | stment, in accordance wi r yes or "N" for no. Is | th 42 CFF this | | | | | | | |
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| | disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo | stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment | th 42 CFF this ndment s for thi | s | | | | | | 22. |
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| 01 | disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. | stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24 | th 42 CFF this ndment s for thi for no 1 October 7 of the o uctions) sated can struction n of the "Y" for on or aff urban to stical an "N" for r r 1. Ente e cost uctions) 9 beds (a 3, "Y" for and/or 25 | s for L. cost re ns) yes cer peas no er | N | N | | Ν | | 22. |
| 01 02 03 | disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. | stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censu | th 42 CFF this ndment s for thi for no 1 October 7 of the c uctions) sated car struction n of the "Y" for on or aff urban to stical ar "N" for r 1. Ente e cost uctions) 9 beds (a 3, "Y" for and/or 25 s days, c | s For cost re ns) yes cer preas no er as pr 3 | N | N | | Ν | | 22. |
| 01 02 03 | disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. | stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censu of identifying the days | th 42 CFF this ndment s for thi for no 1 October 7 of the 0 uctions) sated car struction n of the "Y" for on or aff urban to stical ar "N" for r r 1. Ente e cost uctions) 9 beds (a 3, "Y" for and/or 25 s days, o in this o | s For cost re ns) yes cer preas no er as pr 3 | N | N | | Ν | | 22. |

| SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA | EGIONAL HEAI | Provider CC | N: 15-0064 | Peri od: | | Workshe | m CMS- et S-2 | |
|---|---|---|---|--|--|------------------------------|--------------------------|----------------------------|
| | | | | From 10/0 | 1/2017 0/2018 | Part I Date/Ti 2/28/20 | me Pre | epared |
| | In-State Medicaid paid days | In-State Medicaid eligible unpaid days | Out-of State Medicaid paid days | Out-of State Medicaid eligible unpaid | Medicai HMO day | /s Med | ther li cai d lays | |
| 00 If this provider is an LDDC beenited, enter the | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | | <u>5.00</u> | 24 |
| 00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 6. 00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. | 71 0 | 542 0 | 0 | 0 | 3 | 0 | U | 24. |
| | | | I | | ural S [| | | · |
| 00 Enter your standard geographic classification (not wa | ide) status | at the beg | inning of t | 1. (he | 2 | 2.0 |)0 | 26. |
| cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi | rural. ge) status "2" for ru cation in d | at the end ural. If ap column 2. | of the cos plicable, | t | 2 | | | 27. |
| 00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period. | e number of | periods SC | H status in | Begi nr | 0 ni na: | Endi | na: | 35. |
| | | | | 1. (| | 2.0 | | |
| 00 Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date | | cript line | 36 for numb | er | | | | 36. |
| 00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.01 Is this hospital a former MDH that is eligible for the former MDH that is eligible for the former MDH. | e MDH trans | sitional pa | yment in | s | 0 | | | 37. 37. |
| accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions) O0 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. | of MDH sta | atus. Ifli | ne 37 is | | | | | 38. |
| | | | | Y/ | | Y/I | | |
| | | | or low volu | 1.0 me Y | | 2. C Y | | 39. |
| 00 Does this facility qualify for the inpatient hospital | payment ad | ilustment r | | - | | | | |
| hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) | , (ii), or the mileage i)? Enter i | (iii)? Ent requiremen n column 2 | er in colum ts in "Y" for ye | s | | | | |
| hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii | , (ii), or he mileage i)? Enter i a adjustment per 1. Enter | (iii)? Ent requiremen n column 2 ? Enter "Y "Y" for y | er in colum ts in "Y" for ye " for yes o | s r N | | Ν | | 40. |
| hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) 00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob | , (ii), or he mileage i)? Enter i a adjustment per 1. Enter | (iii)? Ent requiremen n column 2 ? Enter "Y "Y" for y | er in colum ts in "Y" for ye " for yes o | s r N | V | N XVI I I 2 00 | XI X | |
| hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) 00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob | , (ii), or he mileage i)? Enter i a adjustment per 1. Enter | (iii)? Ent requiremen n column 2 ? Enter "Y "Y" for y | er in colum ts in "Y" for ye " for yes o | s r N | V 1.00 | N XVIII 2.00 | | |
| hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) 00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital 00 Does this facility qualify and receive Capital paymen | , (İi), or the mileage i)? Enter i n adjustment ber 1. Enter (see instr | (iii)? Ent requiremen n column 2 ?? Enter "Y "Y" for y ructions) | er in colum ts in "Y" for ye " for yes o es or "N" f | s r N or | | - | | |
| hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) 10 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst | , (İi), or he mileage i)? Enter i adjustment per 1. Enter (see instr t for dispr eption for e | (iii)? Ent requiremen n column 2 ? Enter "Y "Y" for y ructions) roportionat | er in colum ts in "Y" for yes o es or "N" f e share in ry circumst | s N or Accordance ances | 1.00 | 2.00 | 3.00 | 45 |
| hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) 00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital 00 Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) 00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. 00 Is this a new hospital under 42 CFR §412.300(b) PPS c 00 Is the facility electing full federal capital payment | , (ii), or the mileage i)? Enter i the adjustment or adjustment or 1. Enter (see instr (see instr)) (see instr (see instr)) | (iii)? Ent requiremen n column 2 ? Enter "Y "Y" for y ructions) roportionat extraordina I and Wkst | er in colum ts in "Y" for yes o es or "N" f e share in ry circumst . L-1, Pt. yes or "N" | s N or N accordance ances I through for no. | 1.00 | 2.00 N | 3.00 N | 45 46 47 |
| hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) 10 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital 00 Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) 10 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. 00 Is the facility electing full federal capital payment Teaching Hospitals 00 Is this a now hospital involved in training residents in | , (ii), or the mileage i)? Enter i adjustment ber 1. Enter (see instr (see instr) (see instr (see instr) (see instr (see instr) (see instr (see instr) (see instr) (| (iii)? Ent requiremen n column 2 ? Enter "Y "Y" for y ructions) roportionat extraordina l and Wkst nter "Y for /" for yes | er in colum ts in "Y" for yes es or "N" f e share in ry circumst . L-1, Pt. yes or "N" or "N" for | s N or N accordance ances I through for no. no. | 1.00 N N N | 2.00 N N | 3.00 N N | 45 46 47 48 |
| hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) 00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital 00 Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) 00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. 01 Is this a new hospital under 42 CFR §412.300(b) PPS c 02 Is the facility electing full federal capital payment Teaching Hospitals | , (ii), or he mileage i)? Enter i hadjustment her 1. Enter (see instr t for dispr ption for e L, Pt. II apptal? Er ? Enter ") approved GM period durin yes or "N" h of this c (", complete | (iii)? Ent requiremen n column 2 ? Enter "Y "Y" for y ructions) roportionat extraordina l and Wkst nter "Y for (" for yes ME programs ng which re for no in cost report e Worksheet | er in colum ts in "Y" for yes es or "N" f e share in ry circumst . L-1, Pt. yes or "N" or "N" for ? Enter "Y sidents in column 1. ing period? | s N or N accordance ances I through for no. no. " for yes approved I f col umn 1 Enter "Y" | 1.00 N N N N N N N | 2.00 N N | 3.00 N N | |
| hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) 00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital 00 Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) 00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. 00 Is this a new hospital under 42 CFR §412.300(b) PPS c 00 Is this a hospital involved in training residents in or "N" for no. 00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y | <pre>, (ii), or he mileage i)? Enter i adjustment ber 1. Enter (see instr (see instr (see instr (see instr approved for eption for e c. L, Pt. II approved GM period durin yes or "N" th of this c ", complete , if applic pursement for approved for approved for the second br/>second second pre> | (iii)? Ent requiremen n column 2 ? Enter "Y "Y" for y ructions) roportionat extraordina l and Wkst hter "Y for (" for yes ME programs ng which re for no in cost report e Worksheet cable. or physicia | er in colum ts in "Y" for yes es or "N" f e share in ry circumst . L-1, Pt. yes or "N" or "N" for ? Enter "Y sidents in column 1. ing period? E-4. If co | s N or N accordance ances I through for no. no. " for yes approved I f col um 1 Enter "Y" I umn 2 i s | 1.00 N N N N N N N | 2.00 N N | 3.00 N N | 45 46 47 48 56 |

| SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT | A | Provider C | | eriod: | Worksheet S-2 | |
|--|-------------------------------|---------------------------------------|--|------------------------------------|---|-------|
| | | | T (| rom 10/01/2017 p 09/30/2018 | | pareo |
| | | | NAHE 413.85 | Worksheet A | 2/28/2019 1:0 Pass-Through | 2 pm |
| | | | Y/N | Li ne # | Qualification Criterion Code | |
| | | | 1.00 | 2.00 | 3.00 | 1 |
| 00 Are you claiming nursing and allied health education | | | N | | | 60. |
| any programs that meet the criteria under §413.85? (s | see ins Y/N | structions) IME | Direct GME | IME | Direct GME | |
| | 1.00 | 2.00 | 2.00 | 1.00 | F 00 | - |
| 00 Did your hospital receive FTE slots under ACA | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 0.00 | 61 |
| section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) | | | | 0.00 | 0.00 | |
| 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 | | | | | | 61. |
| instructions) 02 Enter the current year total unweighted primary care | | | | | | 61. |
| FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) | | | | | | |
| 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 | | | | | | 61. |
| instructions) 04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). | | | | | | 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. |
| 61.04 minus line 61.03). (see instructions) 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) | | | | | | 61. |
| | Pro | ogram Name | Program Code | Unweighted IME FTE Count | Unweighted Direct GME FTE | |
| | | 1 00 | 2.00 | 2.00 | Count | - |
| 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 | | 1.00 | 2.00 | 3.00 | 4.00 | 61. |
| FTE unweighted count. 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. | | | | 0.00 | 0.00 | 61. |
| | | | 1 | 1 | 1.00 | |
| ACA Provisions Affecting the Health Resources and Serv | vi ces A | Administration | (HRSA) | | 1.00 | |
| 00 Enter the number of FTE residents that your hospital received HRSA PCRE funding (see instruct | trai ned | | | od for which | 0.00 | 62 |
| 01 Énter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progr Teaching Hospitals that Claim Residents in Nonprovider | Teachi ram. (s r Setti | see instruction ngs | ns) | | 0.00 | |
| 00 Has your facility trained residents in nonprovider set "Y" for yes or "N" for no in column 1. If yes, complet | | | 67. (see instru | ictions) | N | 63 |
| | | | Unwei ghted FTEs Nonprovi der Si te | Unwei ghted FTEs in Hospital | Ratio (col. 1/ (col. 1 + col. 2)) | _ |
| Section 5504 of the ACA Base Year FTE Residents in No | | | 1.00 This base year | 2.00 is your cost r | 3.00 reporting | |
| period that begins on or after July 1, 2009 and before OD Enter in column 1, if line 63 is yes, or your facility in the base year period, the number of unweighted non-resident FTEs attributable to rotations occurring in a settings. Enter in column 2 the number of unweighted | y train -primar all non | ned residents Ty care Iprovider | 0.00 | 0. 00 | 0. 000000 | 64 |

| | | ATA Provi der | Fr | eriod: com 10/01/2017 | | | |
|---|---|---|---|---|---|---|---------------|
| | | | To | 09/30/2018 | Date/Ti 2/28/20 | me Prep | pared 2 nm |
| | Program Name | Program Code | Unwei ghted | Unwei ghted | Ratio (c | col. 3/ | |
| | | | FTEs | FTEs in | (col. 3 | | |
| | | | Nonprovider Site | Hospi tal | 4) |) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.0 | 00 | |
| .00 Enter in column 1, if line 63 | | | 0.00 | 0.00 | 0.0. | 000000 | 65. (|
| is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 | | | | | | | |
| divided by (column 3 + column | | | | | | | |
| 4)). (see instructions) | | | Unweighted | Unwei ghted | Ratio (c | col. 1/ | |
| | | | FTEs | FTEs in | (col. 1 | | |
| | | | Nonprovider Site | Hospi tal | 2) |) | |
| | | | 1.00 | 2.00 | 3.0 | 0 | |
| Section 5504 of the ACA Current Y | /ear FTE Residents i | n Nonprovider Settir | | | | | |
| beginning on or after July 1, 201 00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita | unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column | rovider settings. ry care resident 3 the ratio of | 0.00 | 0.00 | 0. | 000000 | 66. |
| (column 1 divided by (column 1 + | | structions) | | | | | |
| | Program Name | | Unweighted | Unweighted | Ratio (c | col 3/ | |
| | Program Name | Program Code | Unweighted FTEs Nonprovider Site | Unweighted FTEs in Hospital | Ratio (c (col. 3 4) | + col . | |
| | Program Name | | FTĔs Nonprovider | FTEsin | (col. 3 4) 5.0 | + col.) | |
| .00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) | U U | Program Code | FTĔs Nonprovider Site 3.00 | FTES in Hospital | (col. 3 4) 5.0 | + col .) | |
| 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 | U U | Program Code | FTĔs Nonprovider Site 3.00 | FTES in Hospital 4.00 0.00 | (col . 3 4) 5. (0 0 | + col .) 00 000000 | |
| 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 25 | Program Code 2.00 | FTĔs Nonprovi der Si te 3.00 0.00 | FTES in Hospi tal 4.00 0.00 1.0 | (col . 3 4) 5. (0 0 2. 00 | + col .) | 67. |
| 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 25 vchiatric Facility (| Program Code 2.00 | FTĔs Nonprovi der Si te 3.00 0.00 | FTES in Hospi tal 4.00 0.00 1.0 | (col . 3 4) 5. (0 0 2. 00 | + col .) 00 000000 | 67. |
| <pre>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)</pre> | 1.00 1.00 2S /chiatric Facility (the facility have a ≥fore November 15, 2 umn 2: Did this fac ≥ 112.424 (d)(1)(iii) ;ate which program y | Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for | FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m | FTES in Hospital 4.00 0.00 1.0 rovider? Y he most o. (see ing o. | (col . 3 4) 5. (0 0 2. 00 | + col .) 00 000000 | 67. 1 |
| <pre>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)</pre> | 1.00 1.00 2S ychiatric Facility (the facility have a effore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii ate which program y y PPS habilitation Facilit | Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi | FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m | FTES in Hospital 4.00 0.00 1.0 rovider? Y he most o. (see ing o. | (col . 3 4) 5. (0 0 2. 00 | + col .)) 0000000 0000000 3.00 | |

| Health Financial Systems FAYETTE REGIONAL | HEALTH SYSTEM | l | In Lie | u of Form CMS- | 2552-10 |
|--|-----------------------------------|----------------------------|---|---|------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider C | | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Pre 2/28/2019 1:0 | epared: |
| | | | | 1.00 | |
| Long Term Care Hospital PPS80.00Is this a long term care hospital (LTCH)? Enter "Y" for yes81.00Is this a LTCH co-located within another hospital for part"Y" for yes and "N" for no. | es and "N" for or all of the | no. cost reportino | g period? Enter | N N | 80. 00 81. 00 |
| TEFRA Providers85.00Is this a new hospital under 42 CFR Section §413.40(f)(1)(i86.00Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. | | | | N | 85. 00 86. 00 |
| 87.00 Is this hospital an extended neoplastic disease care hospit 1886(d) (1) (B) (vi)? Enter "Y" for yes or "N" for no. | al classified | under section | | Ν | 87.00 |
| | | | V 1.00 | XI X 2.00 | _ |
| Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospit | al services? F | nter "V" for | N | Y | 90.00 |
| yes or "N" for no in the applicable column. | | | | | |
| 91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app | licable column | | N | N | 91.00 |
| 92.00 Are title XIX NF patients occupying title XVIII SNF beds (instructions) Enter "Y" for yes or "N" for no in the applic | able column. | <i>,</i> , , | | N | 92.00 |
| 93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column. | of title V an | d XIX? Enter | N | Ν | 93.00 |
| 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column. | and "N" for n | o in the | N | Ν | 94.00 |
| 95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column. | | | 0. 00 N | 0. 00 N | 95.00 96.00 |
| 97.00 If line 96 is "Y", enter the reduction percentage in the ap 98.00 Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" | nterns and res | idents post | 0. 00 Y | 0. 00 Y | 97.00 98.00 |
| column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for the r | | | Y | Y | 98. 01 |
| title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the obed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes | | | Y | Y | 98. 02 |
| 98.03 poes title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y | | | N | Ν | 98.03 |
| for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i | l reimbursed 10 n column 1 for | 1% of title V, and | Ν | Ν | 98.04 |
| <pre>in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in</pre> | | | Y | Y | 98. 05 |
| <pre>column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.</pre> | reimbursed fo n 1 for title | r Wkst. D, V, and in | Y | Y | 98.06 |
| Rural Providers 105.00 Does this hospital qualify as a CAH? | | | N | | 105.00 |
| 106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions) | -inclusive met | hod of paymen [.] | t N | | 106.00 |
| 107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in colur yes, the GME elimination is not made on Wkst. B, Pt. I, col | n 1. (see inst | ructions) lf | N | | 107.00 |
| reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no. | | 5 | N | | 108.00 |
| | Physi cal | Occupational | | Respi ratory | |
| 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. | 1.00 N | 2.00 N | 3.00 N | 4.00 N | 109.00 |
| | | | | 1.00 | - |
| 110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. | "Y" for yes or | "N" for no. I | f yes, | N | 110.00 |

| leal th Financial Systems FAYETTE REGIONAL HEALTH SYSTEM HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC | CN: 15-0064 | Period: From 10/01/ To 09/30/ | 2017 | u of For Workshe Part I Date/Ti 2/28/20 | eet S-2 me Pre | 2 epared: |
|---|---|-------------------------------------|------|---|-------------------|--------------------|
| | | 1.00 | | 2.0 | 00 | - |
| 111.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services. | period? Enter enter the column 2. | . N | | | | 111.00 |
| | | | 1.00 | 2.00 | 3.00 | |
| Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no ir is yes, enter the method used (A, B, or E only) in column 2. If column 2 i 3 either "93" percent for short term hospital or "98" percent for long ter psychiatric, rehabilitation and long term hospitals providers) based on th Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" | s "E", enter rm care (incl ne definition ' for no. | in column udes in CMS | N | | 0 | 115.00 |
| 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y no. | 2 | | Y | | | 117.00 |
| I18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 i claim-made. Enter 2 if the policy is occurrence. | f the policy | ' is | 1 | | | 118.00 |
| | Premiums | Losse | s | Insur | ance | |
| | | | | | | |
| | 1.00 | 2.00 | | 3. (| | - |
| 118.01 List amounts of malpractice premiums and paid losses: | 386, 0 | 59 | 0 | | (| 0118.01 |
| 118.02Are malpractice premiums and paid losses reported in a cost center other t | | 1.00 N | | 2. (| 00 | 118. 02 |
| Administrative and General? If yes, submit supporting schedule listing co and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instru- | ost centers vision in ACA ' for yes or ne Outpatient | | | Y | | 119. 00 120. 00 |
| Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable devices | s charged to | Y | | | | 121.00 |
| patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §1903(Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. | (w)(3) of the in column 2 | N | | | | 122.00 |
| Transplant Center Information 25.00Does this facility operate a transplant center? Enter "Y" for yes and "N" | for no. If | N | | | | 125.00 |
| yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter the certif | ication date | • | | | | 126. 00 |
| in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. | cation date | | | | | 127.00 |
| 28.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. | cation date | | | | | 128.00 |
| 29.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2. | | n | | | | 129.00 |
| 30.00 If this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2. | | | | | | 130.00 |
| 31.00 f this is a Medicare certified intestinal transplant center, enter the ce date in column 1 and termination date, if applicable, in column 2. | | | | | | 131.00 |
| 32.00 If this is a Medicare certified islet transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 33.00 If this is a Medicare certified other transplant center, enter the certifi | | | | | | 132.00 |
| in column 1 and termination date, if applicable, in column 2. 34.00[f this is an organ procurement organization (0P0), enter the 0P0 number i | | | | | | 133.00 |
| and termination date, if applicable, in column 2. All Providers | | | | | | - |
| 40.00 Are there any related organization or home office costs as defined in CMS chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home are claimed, enter in column 2 the home office chain number. (see instruct | office costs | , N | | | | 140. 00 |

| Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE | | Provider CC | | Peri From To | n 10/01/2017 09/30/2018 | Worksheet S- Part I Date/Time Pr 2/28/2019 1: | epared: |
|---|---|-------------------|-------------|----------------------|----------------------------|--|-------------------|
| 1.00 | | 00 | | | 3.00 | <u> </u> | |
| If this facility is part of a chai home office and enter the home off | | | | e name | and address | or the | |
| 41. 00 Name: | Contractor's Name: | | | ctor' s | Number: | | 141.00 |
| 42.00 Street: | PO Box: | | | | | | 142.00 |
| 43. 00 Ci ty: | State: | | Zip Co | de: | | | 143.00 |
| | | | | | | 1.00 | - |
| 44.00 Are provider based physicians' cos | sts included in Worksheet | - <u>Α</u> ? | | | | Y | 144.00 |
| | | | | | | | |
| | | | | | 1.00 | 2.00 | |
| 45.00 If costs for renal services are cl inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N" | for yes or "N" for no i lude Medicare utilizatio | n column 1. If c | column 1 is | | | | 145.00 |
| 46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c | column 1. (See CMS Pub. | | | lf | N | | 146.00 |
| | | | | | | 1.00 | _ |
| 47.00Was there a change in the statisti | cal hasis? Enter "V" for | Ves or "N" for | no | | | 1.00 N | 147.00 |
| 48.00 Was there a change in the order of | | | | | | N | 147.00 |
| 49.00 Was there a change to the simplifi | | | | or no. | | N | 149.00 |
| | | Part A | Part B | 3 | Title V | Title XIX | |
| | | 1.00 | 2.00 | | 3.00 | 4.00 | |
| Does this facility contain a provi or charges? Enter "Y" for yes or ' | | | | | | | |
| 55. 00 Hospi tal | | N | N | | N | N | 155. 00 |
| 56.00 Subprovider - IPF | | N | N | | N | N | 156. 00 |
| 57.00 Subprovider - IRF | | N | N | | N | Ν | 157.00 |
| 58. 00 SUBPROVI DER 59. 00 SNF | | N | N | | N | Ν | 158.00 |
| 60.00HOME HEALTH AGENCY | | N | N N | | N N | N | 159.00 |
| 61. 00 CMHC | | | N | | N | N | 161.00 |
| | | | | • | | | |
| Multicompuc | | | | | | 1.00 | - |
| Multicampus 65.001s this hospital part of a Multica Enter "Y" for yes or "N" for no. | impus hospital that has o | one or more campu | uses in dif | ferent | CBSAs? | N | 165. 00 |
| | Name | County | State | Zip Co | de CBSA | FTE/Campus | |
| | 0 | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) | | | | | | 0.0 | 00166.00 |
| | | | | | | 1.00 | - |
| Health Information Technology (HI | () incentive in the Ameri | can Recovery and | d Reinvestm | nent Ac | t | | |
| 67.001s this provider a meaningful user 68.001f this provider is a CAH (line 10 reasonable cost incurred for the H | 05 is "Y") and is a meani | ngful user (line | | ""), en [.] | ter the | Y | 167.00 0168.00 |
| 68.01 If this provider is a CAH and is r | not a meaningful user, do | es this provider | | | ardshi p | | 168. 01 |
| exception under §413.70(a)(6)(ii)? | | | | | opt !! | | |
| 69.00 If this provider is a meaningful α transition factor. (see instruction | | iu is not a CAH (| (iine 105 i | S "N"), | , enter the | 9.9 | 99169.00 |
| | | | | | Begi nni ng | Endi ng | |
| | | | | | 1.00 | 2.00 | |
| 70.00 Enter in columns 1 and 2 the EHR k period respectively (mm/dd/yyyy) | beginning date and ending | date for the re | eporting | | 10/01/2017 | 09/30/2018 | 170.00 |
| | | | | | 1.00 | 2.00 | |
| 171.00 If line 167 is "Y", does this prov section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s | reported on Wkst. S-3, Pt | . I, line 2, col | . 6? Enter | | N | | 0 171. 00 |

| IOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider C | CN: 15-0064 | Period: From 10/01/2017 To 09/30/2018 | 2/28/2019 1: | epared: |
|--------------|---|--------------------------------------|----------------------|---|---------------------|---------|
| | | | | Y/N | Date | _ |
| | General Instruction: Enter Y for all YES responses. Enter N 1 | for all NO re | snonsos Ent | 1.00 | 2.00 | - |
| | mm/dd/yyyy format. | | Sponses. Ent | | ile ile | |
| | COMPLETED BY ALL HOSPITALS | | | | | |
| | Provider Organization and Operation | | | | | |
| . 00 | Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co | | | N | | 1.00 |
| | reporting period: in yes, enter the date of the change in co | Tullin 2. (366 | Y/N | Date | V/I | |
| | | | 1.00 | 2.00 | 3.00 | |
| . 00 | Has the provider terminated participation in the Medicare Proyes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary. | 5 | N | | | 2.00 |
| . 00 | Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions) | fices, drug r or its the board | N | | | 3. 00 |
| | | | Y/N | Туре | Date | |
| | | | 1.00 | 2.00 | 3.00 | |
| . 00 | Financial Data and Reports Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avail column 3. (see instructions) If no, see instructions. | r Compiled, | N | | | 4.00 |
| . 00 | Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reco | | Y | Y/N | | 5.00 |
| | | | | 1.00 | Legal Oper. 2.00 | |
| | Approved Educational Activities | | | | | |
| . 00 | Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program? | 5 | ne provider i | | | 6.00 |
| . 00 . 00 | Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved an cost reporting period? If yes, see instructions. | | during the | N N | | 7.00 |
| . 00 | Are costs claimed for Interns and Residents in an approved g program in the current cost report? If yes, see instructions. | | cal education | N | | 9.00 |
| 0. 00 | Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions. | | | N | | 10.00 |
| 1.00 | Are GME cost directly assigned to cost centers other than La Teaching Program on Worksheet A? If yes, see instructions. | & R in an App | proved | N | N/ /NI | 11.00 |
| | | | | | Y/N 1.00 | |
| 2.00 | Bad Debts Is the provider seeking reimbursement for bad debts? If yes, | see instruct | tions | | Y | 12.0 |
| | If line 12 is yes, did the provider's bad debt collection pol period? If yes, submit copy. | | | ost reporting | N | 13.00 |
| 4.00 | If line 12 is yes, were patient deductibles and/or co-paymen Bed Complement | | * | | Ν | 14.00 |
| 5.00 | Did total beds available change from the prior cost reporting | <u> </u> | yes, see ins ~t A | tructions. Par | N t B | 15.00 |
| | _ | Y/N | Date | Y/N | Date | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | |
| | PS&R Data | | 1 | | | |
| 6. 00 | Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions) | Y | 10/01/2018 | Y | 10/01/2018 | 16.00 |
| 7.00 | Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date | Ν | | Ν | | 17.00 |
| 8. 00 | in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this | Ν | | N | | 18.00 |
| 9. 00 | cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report | Ν | | Ν | | 19.00 |

Health Financial Systems

| FAYETTE | REGI ONAL | HEALTH | SYSTEM | |
|---------|-----------|--------|--------|--|
| | | | | |

In Lieu of Form CMS-2552-10

| Health Financial Sys | stems FAYETTE REGIONA | L HEALTH SYSTEM | | In Lie | u of Form CM | <u>IS-2552</u> -10 | |
|--------------------------------------|--|-----------------|----------------|---|--------------|--------------------|--|
| | AL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider C | CN: 15-0064 | Period: From 10/01/2017 To 09/30/2018 | | Prepared: | |
| | | - · · · · · | | | 2/28/2019 | 1:02 pm | |
| | | | ption D | Y/N | Y/N | | |
| | r 17 is yes, were adjustments made to PS&R For Other? Describe the other adjustments: | | J | 1.00 N | 3.00 N | 20.00 | |
| | of other besch be the other adjustments. | Y/N | Date | Y/N | Date | | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | | |
| | report prepared only using the provider's | N | | N | | 21.00 | |
| records? If y | yes, see instructions. | | | | | | |
| | | | | | 1.00 | | |
| COMPLEIED BY Capital Relat | COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC | EPI CHILDRENS H | OSPITALS) | | | | |
| | been relifed for Medicare purposes? If yes, se | o instructions | | | | 22.00 | |
| 23.00 Have changes | occurred in the Medicare depreciation expense | | als made duri | ng the cost | | 22.00 | |
| | riod? If yes, see instructions. ses and/or amendments to existing leases enter | ed into during | this cost rep | orting period? | | 24.00 | |
| | If yes, see instructions | | | | | | |
| instructions. 26.00 Were assets s | subject to Sec.2314 of DEFRA acquired during t | he cost reporti | ng period? If | ves, see | | 26.00 | |
| instructions. | | | 0 1 | 5 | | 27.00 | |
| copy. | | | | yes, subili t | | 27.00 | |
| | ns, mortgage agreements or letters of credit e | ntered into dur | ing the cost | reporting | | 28.00 | |
| | es, see instructions. ider have a funded depreciation account and/or | bond funds (De | bt Service Re | serve Fund) | | 29.00 | |
| | funded depreciation account? If yes, see inst debt been replaced prior to its scheduled mat | | debt? If yes, | see | | 30.00 | |
| instructions. 31.00 Has debt beer | n recalled before scheduled maturity without i | ssuance of new | debt? If ves. | see | | 31.00 | |
| instructions. Purchased Ser | | | | | | | |
| 32.00 Have changes | or new agreements occurred in patient care se | | d through con | tractual | | 32.00 | |
| 33.00 If line 32 is | with suppliers of services? If yes, see instr s yes, were the requirements of Sec. 2135.2 ap | | g to competiti | ive bidding? If | | 33.00 | |
| no, see instr Provider-Base | | | | | | | |
| 34.00 Are services | furnished at the provider facility under an a | rrangement with | provi der-base | ed physi ci ans? | | 34.00 | |
| If yes, see i 35 00 If line 34 is | instructions. s yes, were there new agreements or amended ex | isting agreemen | ts with the p | rovi der-based | | 35.00 | |
| | uring the cost reporting period? If yes, see i | | | Y/N | Date | | |
| | | | | 1.00 | 2.00 | | |
| Home Office C | | | | | | | |
| 37.00 If line 36 is | fice costs claimed on the cost report? s yes, has a home office cost statement been p | repared by the | home office? | | | 36.00 37.00 | |
| | s yes , was the fiscal year end of the home of | | | | | 38.00 | |
| the provider? | ? If yes, enter in column 2 the fiscal year en s yes, did the provider render services to oth | d of the home o | ffi ce. | | | 39.00 | |
| see instructi | | | | | | 40.00 | |
| i nstructi ons. | | | | | | | |
| | | 1. | 00 | 2. | 00 | | |
| 41.00 Enter the fir | Preparer Contact Information rst name, last name and the title/position | KYLE | | SMI TH | | 41.00 | |
| respecti vel y. | | | | | | | |
| 42.00 Enter the emp preparer. | oloyer/company name of the cost report | BLUE & CO., LL | С | | | 42.00 | |
| 43.00 Enter the tel | lephone number and email address of the cost rer in columns 1 and 2, respectively. | 317-713-7957 | | KCSMI TH@BLUEAN | DCO. COM | 43.00 | |
| | | | | | | | |

| Heal th | Financial Systems | FAYETTE REGIONAL | HEAL | TH SYSTEM | | In Lieu | 」of Form CMS- | 2552-10 |
|----------|---|------------------|--------|----------------------|-------|---------|---------------|----------------|
| HOSPI TA | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT | QUESTI ONNAI RE | Р | rovider CCN: 15-0064 | Perio | | Worksheet S-2 | |
| | | | | | | | | pared: 2 pm |
| | | | | | | | | |
| | | | | 3.00 | | | | |
| | Cost Report Preparer Contact Information | | | | | | | |
| 41.00 | Enter the first name, last name and the ti | itle/position | SENI 0 | DR MANAGER | | | | 41.00 |
| | held by the cost report preparer in column | ns 1, 2, and 3, | | | | | | |
| | respectively. | | | | | | | |
| 42.00 | Enter the employer/company name of the cost | st report | | | | | | 42.00 |
| | preparer. | | | | | | | |
| 43.00 | Enter the telephone number and email addre | ess of the cost | | | | | | 43.00 |
| | report preparer in columns 1 and 2, respec | cti vel y. | | | | | | |

| | Financial Systems FA | YETTE REGIONAL | Provi der CC | CN: 15-0064 | Peri od: | u of Form CMS-2 Worksheet S-3 | |
|------------------|---|---------------------|--------------|-----------------------|----------------------------------|----------------------------------|--------------------|
| 1105111 | AE AND HOST THE HEALTH GARE COMPLEX STATISTIC | | | N. 13 0004 | From 10/01/2017 To 09/30/2018 | Part I | |
| | | | | | 10 07/30/2010 | 2/28/2019 1:0 | |
| | | | | | | I/P Days / O/P | |
| | | | | | | Visits / Trips | |
| | Component | Worksheet A | No. of Beds | Bed Days Available | CAH Hours | Title V | |
| | | Line Number 1.00 | 2.00 | 3. 00 | 4.00 | 5.00 | |
| 1.00 | Hospital Adults & Peds. (columns 5, 6, 7 and | 30, 00 | 2.00 | <u> </u> | | 5.00 | 1.00 |
| | 8 exclude Swing Bed, Observation Bed and | 00100 | 20 | 77. | | | |
| | 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, 1: | 0.00 | 0 | 7.00 |
| 8.00 | beds) (see instructions) INTENSIVE CARE UNIT | 31.00 | 20 | 7, 30 | 0.00 | 0 | 8.00 |
| 5.00 9.00 | CORONARY CARE UNIT | 31.00 | 20 | 7, 30 | 0.00 | 0 | 9.0 |
| 10.00 | BURN I NTENSI VE CARE UNI T | | | | | | 10.0 |
| 11.00 | SURGI CAL I NTENSI VE CARE UNI T | | | | | | 11.00 |
| 12.00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | 12.00 |
| 13.00 | NURSERY | 43.00 | | | | 0 | 13.00 |
| 14.00 | Total (see instructions) | | 45 | 16, 42 | 0.00 | - | 14.00 |
| 15.00 | CAH visits | | | | | 0 | 15.00 |
| 16.00 | SUBPROVIDER - IPF | 40.00 | 12 | 4, 3 | 30 | 0 | 16.00 |
| 17.00 | SUBPROVIDER - IRF | 41.00 | 0 | | 0 | 0 | 17.00 |
| 18.00 | SUBPROVI DER | 42.00 | 0 | | 0 | 0 | 18.0 |
| 19.00 | SKILLED NURSING FACILITY | | | | | | 19.0 |
| 20.00 | NURSING FACILITY | | | | | | 20.0 |
| 21.00 | OTHER LONG TERM CARE | | | | | | 21.0 |
| 22.00 | HOME HEALTH AGENCY | 101. 00 | | | | 0 | 22.0 |
| 23.00 | AMBULATORY SURGICAL CENTER (D. P.) | 11/ 00 | | | 0 | | 23.0 |
| 24.00 24.10 | HOSPICE | 116.00 30.00 | 0 | | 0 | | 24.0 24.1 |
| 24. 10 25. 00 | HOSPICE (non-distinct part) CMHC - CMHC | 30.00 | | | | | 24.1 |
| 26.00 | RURAL HEALTH CLINIC | | | | | | 25.0 |
| 26.25 | FEDERALLY QUALIFIED HEALTH CENTER | 89.00 | | | | 0 | 26.2 |
| 27.00 | Total (sum of lines 14-26) | 07.00 | 57 | | | 0 | 27.0 |
| 28.00 | Observation Bed Days | | 07 | | | 0 | 28.0 |
| 29.00 | Ambulance Trips | | | | | | 29.00 |
| 30.00 | Employee discount days (see instruction) | | | | | | 30.0 |
| 31.00 | Employee discount days - IRF | | | | | | 31.0 |
| 32.00 | Labor & delivery days (see instructions) | | 0 | | 0 | | 32.0 |
| 32. 01 | Total ancillary labor & delivery room | | | | | | 32. 0 ² |
| | outpatient days (see instructions) | | | | | | |
| 33.00 | LTCH non-covered days | | | | | | 33.00 |
| 33.01 | LTCH site neutral days and discharges | | | | | | 33.0 |

| OSPI - | FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC | AL DATA | Provider CC | CN: 15-0064 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I Date/Time Pre 2/28/2019 1:0 | pared: |
|--------------|--|---------------|--------------|-----------------------|---|---|------------|
| | | I/P Days | / O/P Visits | / Trips | Full Time I | Equi val ents | |
| | Component | Title XVIII | Title XIX | Total All Patients | Total Interns & Residents | Employees On Payroll | |
| | | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| . 00 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) | 835 0 0 | 71 936 | 3, 0 | 80 | | 2.00 |
| . 00 | HMO I PF Subprovi der | 0 | 0 | | | | 3.00 |
| . 00 | HMO I RF Subprovider | 0 | - | | 0 | | 4.00 |
| . 00 | Hospital Adults & Peds. Swing Bed SNF | 0 | 0 | | 0 | | 5.0 |
| . 00 . 00 | Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) | 835 | 0 71 | 3, 00 | 0 80 | | 6.0 7.0 |
| . 00 | INTENSIVE CARE UNIT | 169 | 0 | 20 | 04 | | 8.0 |
| . 00 | CORONARY CARE UNIT | 10, | 0 | | | | 9.0 |
| 0.00 | BURN INTENSIVE CARE UNIT | | | | | | 10.0 |
| 1.00 | SURGICAL INTENSIVE CARE UNIT | | | | | | 11.0 |
| 2.00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | 12.0 |
| 3.00 | NURSERY | | 0 | 3. | 33 | | 13.0 |
| 4.00 | Total (see instructions) | 1,004 | 71 | 3, 5 | | 359.26 | |
| 5.00 | CAH visits | 1,004 | 0 | | 45 0.00 | 357.20 | 14.0 |
| 6.00 | SUBPROVIDER - IPF | 264 | 6 | | 0.00 | 2.83 | |
| 7.00 | SUBPROVIDER - IRF | 204 | 0 | | 0 0.00 | | |
| 8.00 | SUBPROVIDER - TRF | U | 0 | | 0 0.00 | | |
| 9.00 | SKILLED NURSING FACILITY | | 0 | | 0.00 | 0.00 | 19. (|
| 9.00 0.00 | | | | | | | 20. |
| 1.00 | NURSING FACILITY | | | | | | 20.0 |
| | OTHER LONG TERM CARE | | 0 | | 0 0 00 | 0.00 | |
| 2.00 | HOME HEALTH AGENCY | 0 | 0 | | 0 0.00 | 0.00 | |
| 3.00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | | 0.00 | 23.0 |
| 4.00 | HOSPICE | 0 | 0 | | 0 0.00 | 0.00 | |
| 4.10 | HOSPICE (non-distinct part) | | | | 0 | | 24. |
| 5.00 | CMHC - CMHC | | | | | | 25. |
| 6.00 | RURAL HEALTH CLINIC | | - | | | | 26.0 |
| 6. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | | 0 0.00 | | |
| 7.00 | Total (sum of lines 14-26) | | | | 0.00 | 362.09 | |
| 3. 00 | Observation Bed Days | | 0 | 49 | 91 | | 28. |
| 9.00 | Ambulance Trips | 0 | | | | | 29.0 |
| 0. 00 | Employee discount days (see instruction) | | | | 0 | | 30. |
| 1.00 | Employee discount days - IRF | | | | 0 | | 31. |
| 2.00 | Labor & delivery days (see instructions) | 0 | 0 | | 0 | | 32. |
| 2. 01 | Total ancillary labor & delivery room | | | | 0 | | 32. |
| | outpatient days (see instructions) | | | | | | |
| 3.00 | LTCH non-covered days | О | | | | | 33. |
| 3 01 | LTCH site neutral days and discharges | 0 | | | | | 33. |

| HOSPI T | AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC. | AL DATA | Provider CC | CN: 15-0064 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I Date/Time Pre 2/28/2019 1:03 | pared: |
|---|---|---|--------------------------------------|-------------|--|--|---|
| | | Full Time Equivalents | | Di s | charges | | |
| | Component | Nonpai d Workers | Title V | Title XVIII | Title XIX | Total All Patients | |
| | | 11.00 | 12.00 | 13.00 | 14.00 | 15.00 | |
| $\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 24.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 10\\ 25.\ 00\\ 24.\ 10\\ 25.\ 00\\ 24.\ 10\\ 25.\ 00\\ 26.\ 00\\ 28.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 00\\ 31.\ 00\\ 32.\ 00\\ 31.\ 00\\ 32.\ 00\\ 31.\ 00\\ 32.\ 00\\ 31.\ 00\\ 32.\ 00\\ 31.\ 00\\ 32.\ 00\\ 33.\$ | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instructions) | 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 | 0 0 0 0 0 0 0 0 | 2 | 92 17 0 254 0 0 92 17 20 1 0 0 0 0 | 1, 007 1, 007 27 0 0 | 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 14. 00 15. 00 14. 00 20. 00 21. 00 22. 00 23. 00 24. 10 25. 00 24. 10 25. 00 26. 00 27. 00 28. 00 29. 00 20. 00 21. 00 20. 00 21. 00 21. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 20. 00 20. 00 21. 00 20. 00 21. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 20. 00 20. 00 21. 00 20. 00 21. 00 23. 00 24. 10 25. 00 26. 00 26. 00 27. 00 28. 00 29. 00 20. 00 |
| 32. 01 33. 00 33. 01 | Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges | | | | 0 0 | | 32.0 ⁴ 33.00 33.0 ⁴ |

| PI T | AL WAGE INDEX INFORMATION | | | Provider C | F | eriod: rom 10/01/2017 o 09/30/2018 | Worksheet S-3 Part II Date/Time Pre 2/28/2019 1:0 | pared |
|-------|---|------------------------|--------------------|---|---------------|--|--|-------|
| | | Wkst. A Line Number | Amount Reported | Reclassificati on of Salaries (from Wkst. A-6) | | | Average Hourly Wage (col. 4 ÷ col. 5) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | |
| | PART II - WAGE DATA SALARIES | | | | | | | + |
| 0 | Total salaries (see | 200.00 | 21, 076, 613 | 0 | 21, 076, 613 | 796, 746. 00 | 26.45 | 1.0 |
| 0 | instructions) Non-physician anesthetist Part | | 0 | 0 | 0 | 0.00 | 0.00 | 2.0 |
| | A | | Ū | _ | _ | | | |
| 0 | Non-physician anesthetist Part B | | 0 | 0 | C | 0.00 | 0.00 | 3.0 |
| 0 | Physician-Part A - | | 45, 105 | 0 | 45, 105 | 301.00 | 149. 85 | 4. (|
| 1 | Administrative Physicians - Part A - Teaching | | 0 | 0 | | 0.00 | 0.00 | 4. (|
| 0 | Physician and Non | | 3, 443, 065 | - | - | | | |
| | Physician-Part B | | 0 | 0 | 0 | 0.00 | 0.00 | |
| 0 | Non-physician-Part B for hospital-based RHC and FQHC services | | 0 | | | 0.00 | 0.00 | 6. |
| 0 | Interns & residents (in an | 21.00 | 0 | 0 | C | 0.00 | 0.00 | 7. |
| 1 | approved program) Contracted interns and residents (in an approved | | 0 | 0 | С | 0.00 | 0.00 | 7. |
| 0 | programs) Home office and/or related organization personnel | | 0 | 0 | С | 0.00 | 0.00 | 8. |
| 0 | SNĚ | 44.00 | 0 | 0 | C | 0.00 | | |
| 00 | Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS | | 2, 665, 488 | 47, 312 | 2, 712, 800 | 134, 707. 00 | 20. 14 | 10. |
| 00 | Contract Labor: Direct Patient | | 781, 521 | 0 | 781, 521 | 12, 041. 00 | 64. 90 | 11. |
| 00 | Care Contract Labor: Top Level management and other | | 0 | 0 | С | 0.00 | 0.00 | 12. |
| | management and administrative services | | | | | | | |
| 00 | Contract Labor: Physician-Part A - Administrative | | 992, 846 | 0 | 992, 846 | 9, 928. 00 | 100.00 | 13. |
| 00 | Home office and/or related organization salaries and | | 0 | 0 | С | 0.00 | 0.00 | 14. |
| 01 | wage-related costs Home office salaries | | 0 | 0 | 0 | 0.00 | 0.00 | 14. |
| 02 | Related organization salaries | | 0 | 0 | C | 0. 00 | 0.00 | 14. |
| 00 | Home office: Physician Part A - Administrative | | 0 | 0 | C | 0.00 | 0.00 | 15. |
| | Home office and Contract Physicians Part A - Teaching | | 0 | 0 | С | 0.00 | 0.00 | 16. |
| 00 | WAGE-RELATED COSTS Wage-related costs (core) (see | | 3, 709, 305 | 0 | 3, 709, 305 | i | | 17. |
| | instructions) | | | | | | | |
| 00 | Wage-related costs (other) (see instructions) | | 366, 177 | 0 | 366, 177 | | | 18. |
| 00 | Excluded areas | | 536, 832 | 0 | 536, 832 | | | 19. |
| 00 | Non-physician anesthetist Part A | | 0 | 0 | C | | | 20. |
| 00 | Non-physician anesthetist Part | | 0 | 0 | C | | | 21. |
| 00 | B Physician Part A - Administrative | | 4, 278 | 0 | 4, 278 | | | 22. |
| 01 | Physician Part A - Teaching | | 0 | 0 | 0 | | | 22. |
| 00 00 | Physician Part B Wage-related costs (RHC/FQHC) | | 367, 280 0 | 0 | 367, 280 C | | | 23. |
| 00 | Interns & residents (in an | | 0 | 0 | | | | 24. |
| 50 | approved program) Home office wage-related | | 0 | 0 | c | | | 25. |
| 51 | (core) Related organization | | 0 | 0 | c | | | 25. |
| 52 | wage-related (core) Home office: Physician Part A - Administrative - | | 0 | 0 | с | 6 | | 25. |
| 53 | wage-related (core) Home office & Contract Physicians Part A - Teaching - | | 0 | 0 | с | | | 25. |
| | wage-related (core) | | | | | | | 1 |
| 00 | OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department | <u>S</u> 4.00 | 168, 515 | 168, 319 | 336, 834 | 8, 209. 00 | 41.03 | 24 |
| 00 | Administrative & General | 4.00 5.00 | 2, 696, 846 | | | | | |

| Heal th | Financial Systems | FA | YETTE REGIONAL | . HEALTH SYSTEM | | In Lie | eu of Form CMS-2 | 2552-10 |
|---------|--------------------------------|--------------|----------------|------------------|---------------|----------------|---------------------------------|---------|
| HOSPI T | AL WAGE INDEX INFORMATION | | | Provider CO | | Peri od: | Worksheet S-3 | |
| | | | | | | rom 10/01/2017 | | |
| | | | | | I | o 09/30/2018 | Date/Time Pre 2/28/2019 1:02 | |
| | | Wkst. A Line | Amount | Reclassi fi cati | Adj usted | Paid Hours | Average Hourly | |
| | | Number | | on of Salaries | | | Wage (col. 4 ÷ | |
| | | | | (from Wkst. | (col.2 ± col. | | col. 5) | |
| | | | | A-6) | 3) | col. 4 | Í Í | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | |
| 28.00 | Administrative & General under | | 1, 428, 731 | 0 | 1, 428, 731 | l 28, 565. 00 | 50. 02 | 28.00 |
| | contract (see inst.) | | | | | | | |
| 29.00 | Maintenance & Repairs | 6. 00 | 0 | 0 | (| 0.00 | | 29.00 |
| 30.00 | Operation of Plant | 7.00 | 356, 297 | 10, 886 | 367, 183 | 3 16, 920. 00 | | |
| 31.00 | Laundry & Linen Service | 8.00 | 0 | 0 | (| 0.00 | 0.00 | 31.00 |
| 32.00 | Housekeepi ng | 9.00 | 568, 763 | 23, 239 | 592, 002 | 48, 909. 00 | 12. 10 | 32.00 |
| 33.00 | Housekeeping under contract | | 0 | 0 | (| 0.00 | 0.00 | 33.00 |
| | (see instructions) | | | | | | | |
| 34.00 | Dietary | 10.00 | 552, 084 | -290, 346 | 261, 738 | 3 16, 118. 00 | 16. 24 | 34.00 |
| 35.00 | Dietary under contract (see | | 0 | 0 | (| 0.00 | 0.00 | 35.00 |
| | instructions) | | | | | | | |
| 36.00 | Cafeteri a | 11.00 | 0 | 313, 288 | 313, 288 | 3 21, 708. 00 | 14.43 | 36.00 |
| 37.00 | Maintenance of Personnel | 12.00 | 0 | 0 | (| 0.00 | 0.00 | 37.00 |
| 38.00 | Nursing Administration | 13.00 | 779, 138 | 14, 624 | 793, 762 | 2 16, 341. 00 | 48.57 | 38.00 |
| 39.00 | Central Services and Supply | 14.00 | 82, 207 | 3, 662 | 85, 869 | 3, 817. 00 | 22. 50 | 39.00 |
| 40.00 | Pharmacy | 15.00 | 353, 553 | 5, 914 | 359, 467 | 13, 222. 00 | 27.19 | 40.00 |
| 41.00 | Medical Records & Medical | 16.00 | 718, 561 | 74, 380 | 792, 941 | 30, 471. 00 | 26.02 | 41.00 |
| | Records Library | | | | | | | |
| 42.00 | Soci al Servi ce | 17.00 | 0 | 0 | (| 0.00 | 0.00 | 42.00 |
| 43.00 | Other General Service | 18.00 | 0 | 0 | (| 0.00 | 0.00 | 43.00 |

| Heal th | Financial Systems | FA | YETTE REGIONAL | HEALTH SYSTEM | | In Lieu of Form CMS-2552-10 | | | |
|---------|--------------------------------|-------------|----------------|-------------------|---------------|-----------------------------|---------------------------|------|--|
| HOSPI | TAL WAGE INDEX INFORMATION | | | Provider CC | | Period: From 10/01/2017 | Worksheet S-3 Part III | | |
| | | | | | | To 09/30/2018 | | | |
| | | Worksheet A | Amount | Recl assi fi cati | Adj usted | Paid 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 | | 19, 062, 279 | 0 | 19, 062, 27 | 9 793, 476. 00 | 24.02 | 1.00 | |
| | instructions) | | | | | | | | |
| 2.00 | Excluded area salaries (see | | 2, 665, 488 | 47, 312 | 2, 712, 80 | 0 134, 707. 00 | 20. 14 | 2.00 | |
| | instructions) | | | | | | | | |
| 3.00 | Subtotal salaries (line 1 | | 16, 396, 791 | -47, 312 | 16, 349, 47 | 9 658, 769. 00 | 24.82 | 3.00 | |
| | minus line 2) | | | | | | | | |
| 4.00 | Subtotal other wages & related | | 1, 774, 367 | 0 | 1, 774, 36 | 7 21, 969. 00 | 80. 77 | 4.00 | |
| | costs (see inst.) | | | | | | | | |
| 5.00 | Subtotal wage-related costs | | 4, 079, 760 | 0 | 4, 079, 76 | 0.00 | 24.95 | 5.00 | |
| | (see inst.) | | | | | | | | |
| 6.00 | Total (sum of lines 3 thru 5) | | 22, 250, 918 | -47, 312 | 22, 203, 60 | 6 680, 738. 00 | 32.62 | 6.00 | |
| 7.00 | Total overhead cost (see | | 7, 704, 695 | -291, 270 | 7, 413, 42 | 5 275, 340. 00 | 26. 92 | 7.00 | |
| | instructions) | | | | | | | | |
| | | | | | | | | | |

| Heal th | Financial Systems FAYETTE REGIONAL | _ HEALTH SYSTEM | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|-----------------------------|---|--------------------|---------|
| HOSPI T | AL WAGE RELATED COSTS | Provider CCN: 15-0064 | Period: From 10/01/2017 To 09/30/2018 | | |
| | | | | Amount Reported | |
| | | | | 1.00 | |
| | PART IV - WAGE RELATED COSTS | | | | |
| | Part A - Core List | | | | |
| | RETI REMENT COST | | | | |
| 1.00 | 401K Employer Contributions | | | -159, 240 | 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) | | | 0 | 8.00 |
| 8.01 | Health Insurance (Self Funded without a Third Party Adminis | | | 0 | |
| 8.02 | Health Insurance (Self Funded with a Third Party Administra | ator) | | 3, 447, 672 | |
| 8.03 | Health Insurance (Purchased) | | | 0 | |
| 9.00 | Prescription Drug Plan | | | 0 | |
| 10.00 | Dental, Hearing and Vision Plan | | | -91, 028 | 10.00 |
| 11.00 | Life Insurance (If employee is owner or beneficiary) | | | -72, 341 | |
| 12.00 | Accident Insurance (If employee is owner or beneficiary) | | | 0 | |
| 13.00 | Disability Insurance (If employee is owner or beneficiary) | | | -113, 121 | |
| 14.00 | Long-Term Care Insurance (If employee is owner or beneficia | ary) | | | 14.00 |
| 15.00 | 'Workers' Compensation Insurance | | | 93, 821 | |
| 16.00 | Retirement Health Care Cost (Only current year, not the ext | traordinary accrual require | ed by FASB 106. | 0 | 16.00 |
| | Non cumulative portion) | | | | |
| | TAXES | | | | |
| | FICA-Employers Portion Only | | | 1, 497, 210 | |
| 18.00 | Medicare Taxes - Employers Portion Only | | | - | 18.00 |
| 19.00 | Unemployment Insurance | | | 14, 722 | |
| 20.00 | State or Federal Unemployment Taxes | | | 0 | 20.00 |
| | OTHER | | | | |
| 21.00 | Executive Deferred Compensation (Other Than Retirement Cost instructions)) | t Reported on lines 1 throu | ugh 4 above. (see | 0 | 21.00 |
| 22.00 | Day Care Cost and Allowances | | | 0 | 22.00 |
| 23.00 | Tuition Reimbursement | | | 0 | |
| | Total Wage Related cost (Sum of lines 1 -23) | | | 4, 617, 695 | |
| | Part B - Other than Core Related Cost | | | | |
| 25.00 | OTHER WAGE RELATED COSTS | | | 366, 177 | 25.00 |

| Heal th | Financial Systems | FAYETTE REGIONAL HE | ALTH SYSTEM | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|---------------------|-----------------------|-----------------|----------------------------------|---------|
| HOSPI T | AL CONTRACT LABOR AND BENEFIT COST | | Provider CCN: 15-0064 | Peri od: | Worksheet S-3 | |
| | | | | From 10/01/2017 | | aarad. |
| | | | | To 09/30/2018 | Date/Time Prep 2/28/2019 1:02 | |
| | Cost Center Description | | | Contract Labor | | |
| | · · · · · · · · · · · · · · · · · · · | | | 1.00 | 2.00 | |
| | PART V - Contract Labor and Benefit Cost | | | | | |
| | Hospital and Hospital-Based Component Ider | nti fi cati on: | | | | |
| 1.00 | Total facility's contract labor and benefi | t cost | | 0 | 0 | 1.00 |
| 2.00 | Hospi tal | | | 0 | 0 | 2.00 |
| 3.00 | Subprovider - IPF | | | 0 | 0 | 3.00 |
| 4.00 | Subprovider - IRF | | | 0 | 0 | 4.00 |
| 5.00 | Subprovider - (Other) | | | 0 | 0 | 5.00 |
| 6.00 | Swing Beds - SNF | | | 0 | 0 | 6.00 |
| 7.00 | Swing Beds - NF | | | 0 | 0 | 7.00 |
| 8.00 | Hospital-Based SNF | | | | | 8.00 |
| 9.00 | Hospital-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 FAYETTE REGIONAL HEA | LTH SYSTEM | | In Lie | eu of Form CMS-2 | 2552-10 |
|--------------|--|--------------|---------------------|----------------------------------|-----------------------------|---------|
| | | Provider CCN | N: 15-0064 | Peri od: | Worksheet S-1 | 0 |
| | | | | From 10/01/2017 To 09/30/2018 | | |
| | | | | | 1.00 | |
| | Uncompensated and indigent care cost computation | | | | 1.00 | |
| 1.00 | Cost to charge ratio (Worksheet C, Part I line 202 column 3 div | ided by lin | e 202 columr | 1.8) | 0.384194 | 1.00 |
| | Medicaid (see instructions for each line) | | <u>c 202 cor um</u> | | 0.001171 | 1.00 |
| 2.00 | Net revenue from Medicaid | | | | 5, 729, 692 | 2.00 |
| 3.00 | Did you receive DSH or supplemental payments from Medicaid? | | | | Y | 3.00 |
| 4.00 | If line 3 is yes, does line 2 include all DSH and/or supplement | | | ai d? | | 4.00 |
| 5.00 | If line 4 is no, then enter DSH and/or supplemental payments fr | om Medicaid | | | 2, 032, 011 | 5.00 |
| 6.00 7.00 | Medicaid charges Medicaid cost (line 1 times line 6) | | | | 20, 951, 362 8, 049, 388 | |
| 7.00 8.00 | Difference between net revenue and costs for Medicaid program (| line 7 minu | s sum of lir | ups 2 and 5 if | 287, 685 | |
| 0.00 | < zero then enter zero) | | 3 3011 01 111 | | 207,003 | 0.00 |
| | Children's Health Insurance Program (CHIP) (see instructions fo | r each line |) | | - | |
| | Net revenue from stand-alone CHIP | | | | 0 | |
| | Stand-al one CHIP charges | | | | 0 | |
| | Stand-alone CHIP cost (line 1 times line 10) | line 11 min | uo lino (). | f . Jong then | 0 | |
| 12.00 | Difference between net revenue and costs for stand-alone CHIP (enter zero) | iine ii min | us line 9; i | r < zero then | 0 | 12.00 |
| | Other state or local government indigent care program (see inst | ructions fo | r each line) | | 1 | |
| | Net revenue from state or local indigent care program (Not incl | | | | 0 | 13.00 |
| 14.00 | Charges for patients covered under state or local indigent care | e program (N | ot included | in lines 6 or | 0 | 14.00 |
| 15.00 | 10) State or local indigent care program cost (line 1 times line 14 | > | | | 0 | 15.00 |
| | Difference between net revenue and costs for state or local ind | | program (Lir | na 15 minus lina | | |
| 10.00 | 13; if < zero then enter zero) | ingent care | | | 0 | 10.00 |
| | Grants, donations and total unreimbursed cost for Medicaid, CHI | P and state | /local indig | jent care progra | ms (see | 1 |
| | instructions for each line) | | | | - | |
| | Private grants, donations, or endowment income restricted to fu | | | | 0 | |
| | Government grants, appropriations or transfers for support of h Total unreimbursed cost for Medicaid , CHIP and state and local | | | s (sum of lines | 287, 685 | |
| 171.00 | 8, 12 and 16) | i nai gont o | are programe | | 2017 000 | |
| | | | Uni nsured | Insured | Total (col. 1 | |
| | | - | patients | pati ents | + col . 2) | |
| | Uncompensated Care (see instructions for each line) | | 1.00 | 2.00 | 3.00 | |
| 20.00 | Charity care charges and uninsured discounts for the entire fac | ility | 633, 72 | 26 0 | 633, 726 | 20.00 |
| | (see instructions) | | | | | |
| 21.00 | Cost of patients approved for charity care and uninsured discou | ints (see | 243, 47 | 74 C | 243, 474 | 21.00 |
| 22.00 | instructions) Payments received from patients for amounts previously written | off as | | 0 0 | 0 | 22.00 |
| 22.00 | charity care | | | | 0 | 22.00 |
| 23.00 | Cost of charity care (line 21 minus line 22) | | 243, 4 | 74 C | 243, 474 | 23.00 |
| | | | | | 1 00 | |
| 24 00 | Does the amount on line 20 column 2, include charges for patien | it days beyo | nd a length | of stay limit | 1.00 N | 24.00 |
| 21.00 | imposed on patients covered by Medicaid or other indigent care | | na a rengtn | or stuy rimit | | 21.00 |
| 25.00 | If line 24 is yes, enter the charges for patient days beyond th | | care program | n's length of | 0 | 25.00 |
| 24 00 | stay limit Tatal had daht evenence for the entire heerital complex (coo inc | tructions) | | | 4 455 000 | 26.00 |
| | Total bad debt expense for the entire hospital complex (see ins Medicare reimbursable bad debts for the entire hospital complex | | uctions) | | 4, 455, 899 128, 662 | |
| | Medicare allowable bad debts for the entire hospital complex (s | | | | 128, 002 | |
| | Non-Medicare bad debt expense (see instructions) | | | | 4, 257, 957 | |
| | Cost of non-Medicare and non-reimbursable Medicare bad debt exp | ense (see i | nstructions) | | 1, 705, 162 | |
| | Cost of uncompensated care (line 23 column 3 plus line 29) | | | | 1, 948, 636 | |
| | Total unreimbursed and uncompensated care cost (line 19 plus li | ne 30) | | | 2, 236, 321 | 31.00 |
| | | | | | | |

| | Financial Systems FA | YETTE REGIONAL H | | N 15 00/4 | | u of Form CMS-2 | 2552-10 |
|----------------|--|-------------------------|----------------------------|---|---|---|--------------------|
| REGLAS | STFICATION AND ADJUSTMENTS OF IRIAL BALANCE OF | F EXPENSES | Provider CC | 1 | Period: From 10/01/2017 Fo 09/30/2018 | Worksheet A Date/Time Pre | pared: |
| | Cost Center Description | Sal ari es | Other | Total (col. 1 + col. 2) | Reclassificati ons (See A-6) | 2/28/2019 1:0 Reclassified Trial Balance (col. 3 +- col. 4) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | GENERAL SERVICE COST CENTERS | | | | -1 -1 | | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | 1/0 515 | 2, 134, 290 | 2, 134, 290 | | 2, 134, 290 | 1.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 168, 515 | 3, 219, 920 | 3, 388, 43 | | 3, 556, 754 | 4.00 |
| 5.00 7.00 | 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT | 2, 696, 846 356, 297 | 7, 557, 515 1, 718, 276 | 10, 254, 36 ⁻ 2, 074, 573 | | 9, 658, 911 1, 114, 814 | 5.00 7.00 |
| 7.00 | 00701 OPERATION OF PLANT | 350, 297 | 1, 718, 270 | 2,074,37 | | 970, 645 | 7.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 0 | 110, 158 | 110, 158 | | 110, 158 | 8.00 |
| 9.00 | 00900 HOUSEKEEPI NG | 568, 763 | 136, 429 | 705, 192 | | 728, 431 | 9.00 |
| 10.00 | 01000 DI ETARY | 552,084 | 441, 562 | 993, 640 | | 452, 730 | 10.00 |
| 11.00 | 01100 CAFETERI A | 0 | 0 | (| | 563, 858 | 11.00 |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 779, 138 | 63, 916 | 843, 054 | 14, 624 | 857, 678 | 13.00 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 82, 207 | 778, 334 | 860, 54 | 1 -288, 267 | 572, 274 | 14.00 |
| 15.00 | 01500 PHARMACY | 353, 553 | 3, 669, 903 | 4, 023, 450 | | 4, 029, 370 | 15.00 |
| 16.00 | 01600 MEDI CAL RECORDS & LI BRARY | 718, 561 | 233, 273 | 951, 834 | 4 74, 380 | 1, 026, 214 | 16.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 1,852,390 | 1, 136, 174 | 2, 988, 56 | | 2, 639, 769 | 30.00 |
| 31.00 40.00 | 03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF | 793, 726 119, 743 | 205, 201 206, 183 | 998, 92 ⁻ 325, 920 | | 1, 014, 063 | 31.00 40.00 |
| 40.00 | 04000 SUBPROVIDER - TPP 04100 SUBPROVIDER - TRF | 119,743 | 200, 183 | | 3, 120 0 0 | 329, 046 0 | 40.00 |
| 41.00 | 04200 SUBPROVI DER | 0 | 0 | | | 0 | 41.00 |
| 43.00 | 04300 NURSERY | 0 | 0 | | 370, 564 | 370, 564 | 43.00 |
| 101 00 | ANCI LLARY SERVICE COST CENTERS | | | | 0,0,001 | 0,0,001 | 101.00 |
| 50.00 | 05000 OPERATI NG ROOM | 602, 480 | 1, 156, 506 | 1, 758, 980 | 5 12, 101 | 1, 771, 087 | 50.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 1, 210, 556 | 2, 293, 030 | 3, 503, 580 | | 3, 539, 628 | |
| 60.00 | 06000 LABORATORY | 683, 523 | 1, 201, 468 | 1, 884, 99 [.] | 1 27, 863 | 1, 912, 854 | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 415, 123 | 77, 853 | 492, 976 | 6, 575 | 499, 551 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 464, 785 | 63, 789 | 528, 574 | 9, 519 | 538, 093 | 66.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | (| 0 0 | 0 | 69.00 |
| 69.01 | 06901 CARDI AC REHAB | 180, 603 | 32, 088 | 212, 69 | 3, 487 | 216, 178 | 69.01 |
| 71.00 | 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 0 | 0 | (| | 0 | 71.00 |
| 72.00 73.00 | 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS | 0 | 0 | |) 291, 929) 0 | 291, 929 0 | 72.00 73.00 |
| 75.00 | OUTPATIENT SERVICE COST CENTERS | U U | 9 | | <u>ч</u> | 0 | / 3. 00 |
| 91.00 | 09100 EMERGENCY | 1, 270, 605 | 1, 207, 537 | 2, 478, 142 | 2 22, 517 | 2, 500, 659 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| 93.00 | 04050 CLI NI C | 4, 661, 370 | 2, 251, 930 | 6, 913, 300 | 88, 949 | 7, 002, 249 | 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 |
| 05 00 | OTHER REIMBURSABLE COST CENTERS | | | | | | 05 00 |
| 95.00 | 09500 AMBULANCE SERVICES | 0 | 0 | | | 0 | 95.00 101.00 |
| 101.00 | 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 0 | 0 | | | 0 | 101.00 |
| 116 00 | 11600 HOSPI CE | 0 | 0 | (| | 0 | 116.00 |
| 118.00 | | 18, 530, 868 | 29, 895, 335 | 48, 426, 203 | | | |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | (| 0 0 | 0 | 190.00 |
| 191.00 | 19100 RESEARCH | 0 | 0 | (| 0 0 | 0 | 191.00 |
| | 19101 FMH DIAGNOSTIC CENTER | 79, 337 | 20, 269 | 99, 600 | 5 3, 412 | 103, 018 | 191.01 |
| | 19102 WELLNESS | 82, 521 | 146, 239 | 228, 760 | | 230, 350 | |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 10, 783 | 11, 850 | 22, 63 | | 24, 516 | |
| | 19201 RFE | 0 211 | 3, 655 | 3, 65 | | | 192.01 |
| | 19202 MARKETI NG 19203 FOUNDATI ON | 90, 311 | 219, 843 | 310, 154 | | 283, 518 | |
| | 19203 FOUNDATION 19206 HEART CENTER | 0 | 0 | (| | | 192. 03 192. 06 |
| | 19206 HEART CENTER | 0 2, 214, 109 | 0 1, 336, 829 | 3, 550, 938 | | 0 3, 589, 595 | |
| | 19208 OCCUPATI ONAL MED | 2,214,107 | 667 | 3, 550, 456 | | | 192.07 |
| | 19210 HOSPI TALI ST | 0 | 593, 455 | 593, 45 | | 598, 955 | |
| | 07950 OTHER NONREI MBURSABLE COST CENTERS | Ő | -15 | -1! | | | 194.00 |
| | 07951 OTHER NONREI MBURSABLE COST CENTERS | 68, 684 | 20, 354 | 89, 038 | | 89, 038 | 194.01 |
| 200.00 | TOTAL (SUM OF LINES 118 through 199) | 21, 076, 613 | 32, 248, 481 | 53, 325, 094 | 4 0 | 53, 325, 094 | 200. 00 |
| | | | | | | | |

| | Financial Systems FA SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O | AYETTE REGIONAL | HEALTH SYSTEM Provider CCN: 15-0064 | In Lieu of Form CMS Period: Worksheet A | |
|------------------|---|----------------------------------|--|--|--------------------|
| 1120210 | | | | From 10/01/2017 To 09/30/2018 Date/Time Pi 2/28/2019 1 | repared: |
| | Cost Center Description | Adjustments (See A-8) 6.00 | Net Expenses For Allocation 7.00 | | |
| | GENERAL SERVICE COST CENTERS | 0.00 | 7.00 | | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | -52, 661 | 2,081,629 | | 1.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 0 | 3, 556, 754 | | 4.00 |
| 5.00 | 00500 ADMINISTRATIVE & GENERAL | -2, 441, 189 | 7, 217, 722 | | 5.00 |
| 7.00 | 00700 OPERATION OF PLANT | -382 | 1, 114, 432 | | 7.00 |
| 7.01 | 00701 OPERATION OF PLANT | 0 | 970, 645 | | 7.01 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 0 | 110, 158 | | 8.00 |
| 9.00 | 00900 HOUSEKEEPI NG | 0 | 728, 431 | | 9.00 |
| 10.00 | 01000 DI ETARY | 0 | 452, 730 | | 10.00 |
| 11.00 | | -251, 809 | 312, 049 | | 11.00 |
| 13.00 | 01300 NURSING ADMINISTRATION | -353 | 857, 325 | | 13.00 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 1 502 457 | 572, 274 | | 14.00 |
| 15.00 | | -1, 502, 457 | 2, 526, 913 | | 15.00 16.00 |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | -8, 101 | 1,018,113 | | 18.00 |
| 30.00 | 03000 ADULTS & PEDIATRICS | -494, 860 | 2, 144, 909 | | 30.00 |
| 31.00 | 03100 I NTENSI VE CARE UNI T | 474,000 | 1, 014, 063 | | 31.00 |
| 40.00 | 04000 SUBPROVI DER – I PF | 0 | 329, 046 | | 40.00 |
| 41.00 | 04100 SUBPROVI DER – I RF | 0 | 0 | | 41.00 |
| 42.00 | 04200 SUBPROVI DER | 0 | 0 | | 42.00 |
| 43.00 | 04300 NURSERY | 0 | 370, 564 | | 43.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | |
| 50.00 | 05000 OPERATING ROOM | -859, 531 | 911, 556 | | 50.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | -762, 261 | 2, 777, 367 | | 54.00 |
| 60.00 | 06000 LABORATORY | 0 | 1, 912, 854 | | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0 | 499, 551 | | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | -18, 230 | 519, 863 | | 66.00 |
| 69.00 | | 0 | 0 | | 69.00 |
| 69. 01 71. 00 | 06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 216, 178 | | 69.01 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 291, 929 | | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 73.00 |
| | OUTPATIENT SERVICE COST CENTERS | - | | | |
| 91.00 | 09100 EMERGENCY | -898, 277 | 1, 602, 382 | | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | 92.00 |
| 93.00 | 04050 CLI NI C | -3, 847, 327 | 3, 154, 922 | | 93.00 |
| | 04950 BI C | 0 | 0 | | 93.01 |
| 93.05 | 04954 PODI ATRY | 0 | 0 | | 93.05 |
| 05 00 | OTHER REIMBURSABLE COST CENTERS | | | | |
| | 09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY | 0 | 0 | | 95.00 101.00 |
| 101.00 | SPECIAL PURPOSE COST CENTERS | 0 | 0 | | |
| 116 00 | 11600 HOSPI CE | 0 | 0 | | 116.00 |
| 118.00 | | -11, 137, 438 | | | 118.00 |
| | NONREI MBURSABLE COST CENTERS | | | | |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | | 190.00 |
| 191.00 | 19100 RESEARCH | 0 | 0 | | 191.00 |
| 191.01 | 19101 FMH DIAGNOSTIC CENTER | 0 | 103, 018 | | 191.01 |
| | 19102 WELLNESS | 0 | 230, 350 | | 191.02 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | 24, 516 | | 192.00 |
| | 19201 RFE | 0 | 3, 655 | | 192.01 |
| | 19202 MARKETI NG | 0 | 283, 518 | | 192.02 |
| | 19203 FOUNDATION | 0 | 0 | | 192.03 |
| | 19206 HEART CENTER 19207 WVCP | 0 | Ŭ | | 192. 06 192. 07 |
| | 19207 WVCP 19208 OCCUPATIONAL MED | 0 | 3, 589, 595 | | 192.07 |
| | 19210 HOSPI TALI ST | 0 | 667 598, 955 | | 192.08 |
| | 07950 OTHER NONREIMBURSABLE COST CENTERS | 0 | -15 | | 192.10 |
| | 07951 OTHER NONREI MBURSABLE COST CENTERS | 0 | 89, 038 | | 194.01 |
| 200.00 | | -11, 137, 438 | | | 200.00 |
| | | | | | |

| | inancial Systems | T <i>F</i> | YETTE REGIONAL | | " CN: 15-0064 | Peri od: | u of Form CMS Worksheet A | |
|--------|--|---------------------|--------------------|------------------|------------------|----------------------------------|------------------------------|---------|
| | | | | | | From 10/01/2017 To 09/30/2018 | Date/Time P | repared |
| | | | | | | | 2/28/2019 1 | :02 pm |
| | Cost Center | Increases Line # | Salary | Other | | | | |
| | 2.00 | 3.00 | 4.00 | 5.00 | | | | |
| ŀ | A - CAFETERIA RECLASS | 3.00 | 4.00 | 5.00 | | | | |
| | CAFETERIA | 11.00 | 313, 288 | 250, 570 | | | | 1.0 |
| | TOTALS | | 313, 288 | 250, 570 | | | | |
| E | B - NURSERY RECLASS | | | | | | | |
| 00 | NURSERY | 43.00 | 283, 896 | 86, 668 | | | | 1.0 |
| | TOTALS | | 283, 896 | 86, 668 | | | | |
| (| C - COACH RECLASS | | | | | | | |
| | EMPLOYEE BENEFITS DEPARTMENT | 4.00 | 168, 319 | 0 | | | | 1. (|
| | ADMI NI STRATI VE & GENERAL | 5.00 | 212, 287 | 0 | | | | 2.0 |
| | OPERATION OF PLANT | 7.00 | 10, 886 | 0 | | | | 3. |
| | HOUSEKEEPING | 9.00 | 23, 239 | 0 | | | | 4. |
| | DI ETARY | 10.00 | 22, 942 | 0 | | | | 5. |
| | NURSING ADMINISTRATION | 13.00 | 14, 624 | 0 | | | | 6. |
| | CENTRAL SERVICES & SUPPLY | 14.00 | 3, 662 | 0 | | | | 7. |
| | PHARMACY | 15.00 | 5, 914 | 0 0 | | | | 8. |
| | MEDICAL RECORDS & LIBRARY ADULTS & PEDIATRICS | 16.00 30.00 | 74, 380 21, 769 | 0 | | | | 9. |
| | INTENSIVE CARE UNIT | 30.00 31.00 | 21, 769 15, 136 | 0 | | | | 11. |
| | SUBPROVIDER – IPF | 40.00 | 3, 120 | 0 | | | | 12. |
| | OPERATING ROOM | 40.00 50.00 | 12, 101 | 0 | | | | 13. |
| | RADI OLOGY-DI AGNOSTI C | 54.00 | 36, 042 | 0 | | | | 14. |
| | LABORATORY | 60,00 | 27, 863 | 0 | | | | 15. |
| | RESPIRATORY THERAPY | 65.00 | 6, 575 | 0 | | | | 16. |
| | PHYSICAL THERAPY | 66.00 | 9, 519 | 0 | | | | 17. |
| | CARDI AC REHAB | 69.01 | 3, 487 | 0 | | | | 18. |
| | EMERGENCY | 91.00 | 22, 517 | 0 | | | | 19. |
| . 00 | CLINIC | 93.00 | 88, 949 | 0 | | | | 20. |
| .00 F | FMH DIAGNOSTIC CENTER | 191.01 | 3, 412 | 0 | | | | 21. |
| . 00 | NELLNESS | 191.02 | 1, 590 | 0 | | | | 22. |
| . 00 F | PHYSICIANS' PRIVATE OFFICES | 192.00 | 1, 883 | 0 | | | | 23. |
| . 00 🛛 | MARKETING | 192.02 | 1, 278 | 0 | | | | 24. |
| .00 1 | MVCP | 192.07 | 38, 657 | 0 | | | | 25. |
| | HOSPI TALI ST | <u> </u> | <u>5, 5</u> 00 | 00 | | | | 26. |
| L . | TOTALS | | 835, 651 | 0 | | | | |
| | D - MARKETING RECLASS | | I | | | | | |
| | ADMI NI STRATI VE & GENERAL | 5.00 | 8, 128 | 1 <u>9, 7</u> 86 | | | | 1. |
| | TOTALS | | 8, 128 | 19, 786 | | | | _ |
| - | E - HOSPITAL UTILITIES | | | 070 / 15 | | | | |
| - | DPERATION OF PLANT | | | 970, 645 | | | | 1. |
| | | | 0 | 970, 645 | | | | - |
| | F - IMPLANTABLE DEVICES | 72.00 | 0 | 291, 929 | | | | 1 |
| | PATIENTS | 12.00 | U | 291, 929 | | | | 1. |
| | TOTALS | + | | 291,929 | | | | |
| - | Grand Total: Increases | | 1, 440, 963 | 1, 619, 598 | | | | 500. |

| | Incial Systems | Γ <i>Ͱ</i> | YETTE REGIONAL | | | | u of Form CMS-255 |
|-----------------|----------------------------|-----------------|------------------|-------------------|--------------|---|---|
| CLASSI FI C | LATLONS | | | Provi der | CCN: 15-0064 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 Date/Time Prepar 2/28/2019 1:02 p |
| | | Decreases | | | | | · · · · · · · · · · · · · · · · · · · |
| | Cost Center | Line # | Salary | Other | Wkst. A-7 Re | f. | |
| | 6. 00 | 7.00 | 8.00 | 9.00 | 10.00 | | |
| | CAFETERIA RECLASS | | | | 1 | | |
| 00 <u>DIE</u> T | | | <u>313, 2</u> 88 | 25 <u>0, 5</u> 70 | <u> </u> | Q | |
| TOTA | - | | 313, 288 | 250, 570 |) | | |
| | NURSERY RECLASS | | | | 1 | | |
| | <u>TS & PEDIATRICS</u> | | 283, 896 | 8 <u>6, 6</u> 68 | | Q | |
| TOTA | - | | 283, 896 | 86, 668 | 3 | | |
| | COACH RECLASS | | | | | - | |
| | NI STRATI VE & GENERAL | 5.00 | 835, 651 | C | | 0 | - |
| 00 | | 0.00 | 0 | C | | 0 | 1 |
| 00 | | 0.00 | 0 | C | | 0 | |
| 00 | | 0.00 | 0 | C | | 0 | 4 |
| 00 | | 0.00 | 0 | C | | 0 | Ę |
| 00 | | 0.00 | 0 | C | | 0 | 6 |
| 00 | | 0.00 | 0 | C | | 0 | |
| 00 | | 0.00 | 0 | C | | 0 | 8 |
| 00 | | 0.00 | 0 | C | | 0 | G |
| . 00 | | 0.00 | 0 | C | | 0 | 10 |
| . 00 | | 0.00 | 0 | C | | 0 | 1' |
| . 00 | | 0.00 | 0 | C | | 0 | 12 |
| . 00 | | 0.00 | 0 | C | | 0 | 13 |
| . 00 | | 0.00 | 0 | C | | 0 | 14 |
| . 00 | | 0.00 | 0 | C | | 0 | 15 |
| . 00 | | 0.00 | 0 | C | | 0 | 16 |
| . 00 | | 0.00 | 0 | C | | 0 | 17 |
| . 00 | | 0.00 | 0 | C | | 0 | 18 |
| . 00 | | 0.00 | 0 | C | | 0 | 19 |
| . 00 | | 0.00 | 0 | C | | 0 | 20 |
| . 00 | | 0.00 | 0 | C | D | 0 | 21 |
| . 00 | | 0.00 | 0 | C | - | 0 | 22 |
| . 00 | | 0.00 | 0 | C | | 0 | 23 |
| 00 | | 0.00 | 0 | C | | 0 | 24 |
| . 00 | | 0.00 | 0 | C | D | 0 | 25 |
| . 00 | | 0.00 | 0 | (| | 0 | 26 |
| TOTA | | | 835, 651 | 0 |) | | |
| | MARKETING RECLASS | | | | 1 | - | |
| | <pre>KETING</pre> | 1 <u>92.</u> 02 | <u> </u> | 1 <u>9, 7</u> 86 | | 0 | |
| TOTA | | | 8, 128 | 19, 786 | b | | |
| | HOSPITAL UTILITIES | | | | T | | |
| | RATION_OF_PLANT | 7.00 | 0 | <u>970, 6</u> 45 | | 0 | |
| TOTA | - | | 0 | 970, 645 | 5 | | |
| | IMPLANTABLE DEVICES | | | | | | |
| OO CENT | TRAL_SERVICES & SUPPLY | 14.00 | 0 | 291, 929 | 9 | 0 | |
| TOTA | als — — — — — — | + | | 291, 929 | 9 | 7 | |
| 0 00 Gran | nd Total: Decreases | | 1, 440, 963 | 1, 619, 598 | 2 | | 500 |

| RECONC | ILIATION OF CAPITAL COSTS CENTERS | | Provider CC | N: 15-0064 | Period: From 10/01/2017 | | |
|--------|--|------------------|--------------|----------------|----------------------------|------------------------------------|----------------|
| | | | | | To 09/30/2018 | B Date/Time Prep 2/28/2019 1:02 | pared: 2 pm |
| | | | | Acqui si ti on | S | | · |
| | | Begi nni ng | Purchases | Donati on | Total | Di sposal s and | |
| | | Bal ances | | | | Retirements | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE | | | | | | |
| 1.00 | Land | 1,003,725 | 0 | | 0 0 | 0 0 | 1.00 |
| 2.00 | Land Improvements | 471, 366 | 20, 709 | | 0 20, 709 | 9 0 | 2.00 |
| 3.00 | Buildings and Fixtures | 51, 320, 484 | 1, 975, 314 | | 0 1, 975, 314 | 1 0 | 3.00 |
| 4.00 | Building Improvements | 0 | 0 | | 0 0 | 0 0 | 4.00 |
| 5.00 | Fixed Equipment | 22, 981, 870 | -4, 489, 842 | | 0 -4, 489, 842 | 2 0 | 5.00 |
| 5.00 | Movable Equipment | 1, 143, 979 | 6, 458, 987 | | 0 6, 458, 987 | 7 0 | 6.00 |
| 7.00 | HIT designated Assets | 0 | 0 | | 0 0 | 0 0 | 7.00 |
| 3.00 | Subtotal (sum of lines 1-7) | 76, 921, 424 | 3, 965, 168 | | 0 3, 965, 168 | 3 0 | 8.00 |
| 9.00 | Reconciling Items | 0 | 0 | | 0 0 | 0 0 | 9.00 |
| 10.00 | Total (line 8 minus line 9) | 76, 921, 424 | 3, 965, 168 | | 0 3, 965, 168 | 3 0 | 10.00 |
| | | Endi ng Bal ance | Fully | | | | |
| | | 5 | Depreci ated | | | | |
| | | | Assets | | | | |
| | | 6.00 | 7.00 | | | | |
| | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE | T BALANCES | | | | | |
| 1.00 | Land | 1, 003, 725 | 0 | | | | 1.00 |
| 2.00 | Land Improvements | 492, 075 | 0 | | | | 2.00 |
| 3.00 | Buildings and Fixtures | 53, 295, 798 | 0 | | | | 3.00 |
| 1.00 | Building Improvements | 0 | 0 | | | | 4.00 |
| 5.00 | Fixed Equipment | 18, 492, 028 | 0 | | | | 5.00 |
| . 00 | Movable Equipment | 7, 602, 966 | 0 | | | | 6.00 |
| 7.00 | HIT designated Assets | 0 | o | | | | 7.00 |
| 3.00 | Subtotal (sum of lines 1-7) | 80, 886, 592 | o | | | | 8.00 |
| 9.00 | Reconciling Items | 0 | o | | | | 9.00 |
| 10.00 | Total (line 8 minus line 9) | 80, 886, 592 | o | | | | 10.00 |

| Heal th | Financial Systems F | AYETTE REGIONAL | HEALTH SYSTEM | | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|-------------------|----------------|---------------|---|-----------------------------|---------|
| RECON | CILIATION OF CAPITAL COSTS CENTERS | | Provider CC | CN: 15-0064 | Period: From 10/01/2017 To 09/30/2018 | Date/Time Pre | pared: |
| | | | | | | 2/28/2019 1:0 | 2 pm |
| | | | SU | IMMARY OF CAP | PI TAL | | |
| | Cost Center Description | Depreciation | Lease | Interest | Insurance (see instructions) | Taxes (see instructions) | |
| | | 9.00 | 10.00 | 11.00 | 12.00 | 13.00 | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLUN | N 2, LINES 1 a | nd 2 | | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 2, 134, 290 | 0 | | 0 0 | 0 | 1.00 |
| 3.00 | Total (sum of lines 1-2) | 2, 134, 290 | 0 | | 0 0 | 0 | 3.00 |
| | | SUMMARY O | F CAPITAL | | | | |
| | Cost Center Description | Other | Total (1) (sum | 1 | | | |
| | | Capi tal -Rel ate | of cols. 9 | | | | |
| | | d Costs (see | through 14) | | | | |
| | | instructions) | | | | | |
| | | 14.00 | 15.00 | | | | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLUN | | | | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 0 | 2, 134, 290 | | | | 1.00 |
| 3.00 | Total (sum of lines 1-2) | 0 | 2, 134, 290 | | | | 3.00 |

| Health Financial Systems FA | YETTE REGIONAL | HEALTH SYSTEM | | In Lie | u of Form CMS-2 | 2552-10 |
|---|----------------|--------------------------|---------------------------|---|----------------------------------|---------|
| RECONCILIATION OF CAPITAL COSTS CENTERS | | Provider C | | Period: From 10/01/2017 To 09/30/2018 | Date/Time Pre | pared: |
| | COMF | PUTATION OF RAT | TI OS | ALLOCATION OF | 2/28/2019 1:02 OTHER CAPI TAL | 2 рш |
| | | | | | | |
| Cost Center Description | Gross Assets | Capi tal i zed Leases | Gross Assets for Ratio | Ratio (see instructions) | Insurance | |
| | | 200303 | (col . 1 - col 2) | | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| PART III - RECONCILIATION OF CAPITAL COSTS CE | INTERS | | _ | | | |
| 1.00 CAP REL COSTS-BLDG & FIXT | 2, 134, 290 | 0 | 2, 134, 29 | 0 1.000000 | 0 | 1.00 |
| 3.00 Total (sum of lines 1-2) | 2, 134, 290 | | 2, 134, 29 | 0 1.000000 | 0 | 3.00 |
| | ALLOCAT | TION OF OTHER (| CAPITAL | SUMMARY C | F CAPITAL | |
| Cost Center Description | Taxes | Other | Total (sum of | Depreciation | Lease | |
| | | Capi tal -Rel ate | | | | |
| | | d Costs | through 7) | | | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| PART III - RECONCILIATION OF CAPITAL COSTS CE | | 0 | 1 | 0 0 0 0 0 0 | 0 | 1 00 |
| 1.00 CAP REL COSTS-BLDG & FLXT | 0 | - | | 0 2, 124, 369 | | 1.00 |
| 3.00 Total (sum of lines 1-2) | 0 | • | I JMMARY OF CAPI | 0 2, 124, 369 | 0 | 3.00 |
| | | 50 | JMMARY OF CAPT | | | |
| Cost Center Description | Interest | Insurance (see | | | Total (2) (sum | |
| | | instructions) | instructions) | | | |
| | | | | d Costs (see | through 14) | |
| | 11.00 | 10.00 | 10.00 | instructions) | 45.00 | |
| | 11.00 | 12.00 | 13.00 | 14.00 | 15.00 | |
| PART III - RECONCILIATION OF CAPITAL COSTS CE | - | | | | 0.001.(00 | 1 00 |
| 1.00 CAP REL COSTS-BLDG & FLXT | -42, 740 | | | 0 0 | _/ / | 1.00 |
| 3.00 Total (sum of lines 1–2) | -42, 740 | 0 | l | 0 0 | 2, 081, 629 | 3.00 |

| | Financial Systems MENTS TO EXPENSES | FA | YETTE REGIONAL | _ HEALTH SYSTEM Provider CCN: 15-0064 | Peri od: | u of Form CMS-2 Worksheet A-8 | 2552-10 |
|----------------|---|--------|-------------------|--|----------------------------------|----------------------------------|----------------|
| | | | | | From 10/01/2017 To 09/30/2018 | Date/Time Prep 2/28/2019 1:02 | |
| | | | | Expense Classification of To/From Which the Amount i | | | |
| | Cost Center Description | | Amount | Cost Center | | Wkst. A-7 Ref. | |
| . 00 | Investment income - CAP REL | 1.00 | 2.00 | 3.00 CAP REL COSTS-BLDG & FIXT | 4.00 | 5.00 0 | 1.00 |
| 2.00 | COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL | | 0 | *** Cost Center Deleted *** | * 2.00 | 0 | 2.00 |
| 3.00 | COSTS-MVBLE EQUIP (chapter 2) Investment income - other | | 0 | | 0.00 | 0 | 3. 0 |
| | (chapter 2) | | - | | | | |
| . 00 | Trade, quantity, and time discounts (chapter 8) | | 0 | | 0.00 | 0 | 4.0 |
| . 00 | Refunds and rebates of expenses (chapter 8) | | 0 | | 0.00 | 0 | 5.0 |
| . 00 | Rental of provider space by suppliers (chapter 8) | | 0 | | 0.00 | 0 | 6.0 |
| . 00 | Telephone services (pay stations excluded) (chapter | | O | | 0.00 | 0 | 7.0 |
| . 00 | 21) Tel evi si on and radi o servi ce | | 0 | | 0.00 | 0 | 8.0 |
| 9. 00 0. 00 | (chapter 21) Parking Lot (chapter 21) Provider-based physician | A-8-2 | 0 -5, 923, 261 | | 0.00 | 0 0 | |
| 1. 00 | adjustment Sale of scrap, waste, etc. | В | -12 | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | 11. 0 |
| 2.00 | (chapter 23) Related organization transactions (chapter 10) | A-8-1 | 0 | | | 0 | 12. 0 |
| 3.00 | Laundry and linen service | | 0 | | 0.00 | 0 | |
| 4.00 5.00 | Cafeteria-employees and guests Rental of quarters to employee and others | В | -249, 334 0 | CAFETERI A | 11.00 0.00 | 0 0 | |
| 6. 00 | Sale of medical and surgical supplies to other than patients | | C | | 0.00 | 0 | 16. 0 |
| 7.00 | Sale of drugs to other than patients | | C | | 0.00 | 0 | 17.0 |
| 8. 00 | Sale of medical records and abstracts | А | -8, 101 | MEDICAL RECORDS & LIBRARY | 16.00 | 0 | 18.0 |
| 9. 00 | Nursing and allied health education (tuition, fees, books, etc.) | | O | 5 | 0.00 | 0 | 19. 0 |
| 0.00 | Vending machines Income from imposition of | B A | | CAFETERIA CAP REL COSTS-BLDG & FIXT | 11. 00 1. 00 | 0 11 | 20. C 21. C |
| 1.00 | interest, finance or penalty charges (chapter 21) | | 12, 710 | | 1.00 | | 21.0 |
| 2. 00 | Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments | | C | | 0.00 | 0 | 22. C |
| 3. 00 | Adjustment for respiratory therapy costs in excess of | A-8-3 | O | RESPI RATORY THERAPY | 65.00 | | 23. C |
| 4. 00 | limitation (chapter 14) Adjustment for physical therapy costs in excess of | A-8-3 | C | PHYSI CAL THERAPY | 66.00 | | 24.0 |
| 5. 00 | limitation (chapter 14) Utilization review - physicians' compensation | | C | *** Cost Center Deleted ** | * 114.00 | | 25. C |
| 6. 00 | (chapter 21) Depreciation - CAP REL COSTS PLDC & ELYT | | C | CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 26. C |
| 7.00 | COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP | | C | *** Cost Center Deleted ** | * 2.00 | 0 | 27. C |
| 8.00 | Non-physician Anesthetist | | 0 | *** Cost Center Deleted *** | | | 28.0 |
| 9.00 0.00 | Physicians' assistant Adjustment for occupational therapy costs in excess of | A-8-3 | 0 | *** Cost Center Deleted ** | * 0.00 * 67.00 | 0 | 29. 0 30. 0 |
| 0. 99 | limitation (chapter 14) Hospice (non-distinct) (see | | 0 | ADULTS & PEDIATRICS | 30.00 | | 30. 9 |
| 1. 00 | instructions) Adjustment for speech pathology costs in excess of | A-8-3 | 0 | *** Cost Center Deleted ** | * 68.00 | | 31.0 |
| 2. 00 | limitation (chapter 14) CAH HIT Adjustment for | | C | | 0.00 | 0 | 32.0 |
| 33.00 | Depreciation and Interest COMMUNITY REVIEW | В | -219. 522 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 33. 0 |

| Heal th | Financial Systems | FA | YETTE REGIONAL | HEALTH SYSTEM | In Lie | eu of Form CMS-2 | 2552-10 |
|---------|---------------------------------------|-----------------|----------------|-----------------------------|----------------------------|------------------|----------------|
| ADJUST | MENTS TO EXPENSES | | | Provider CCN: 15-0064 | Period: From 10/01/2017 | Worksheet A-8 | |
| | | | | | To 09/30/2018 | | pared: 2 pm |
| | | | | Expense Classification of | | | |
| | | | | To/From Which the Amount i | s to be Adjusted | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Cost Center Description | Basi s/Code (2) | Amount | Cost Center | Line # | Wkst. A-7 Ref. | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 33.01 | MI SC REVENUE | В | -137, 875 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 33.01 |
| 33.02 | PFS BILLING SVC-OTHER REVENUE | В | - 300 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 33. 02 |
| 33.03 | VENDOR REBATE/REFUND OTHER REV | | | ADMI NI STRATI VE & GENERAL | 5.00 | | 00.00 |
| 33.04 | COLLECTION FEES-OTHER REV | В | -538 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 00.01 |
| 33.05 | PURCHASE DI SC | В | | ADMI NI STRATI VE & GENERAL | 5.00 | | 00.00 |
| 33.06 | EDUCATION & TRAINING | В | | NURSING ADMINISTRATION | 13.00 | | 00.00 |
| 33.07 | EMPLOYEE DRUG SALES | В | | PHARMACY | 15.00 | | 00.07 |
| 33.08 | PHY TH SCHOOL REV | В | | PHYSI CAL THERAPY | 66.00 | | 00.00 |
| 33.09 | I HA DUES | A | -1, 031 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 00.07 |
| 33.10 | TELEVI SI ON | A | -1, 908 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 001.0 |
| 33.11 | TELEVISION ELECTRICITY | A | -382 | OPERATION OF PLANT | 7.00 | 0 | 000000 |
| 33.12 | 24TH ST DEPRECIATION | A | | CAP REL COSTS-BLDG & FIXT | 1.00 | | 00.12 |
| 33.13 | PHYSICIAN RECRUITMENT | A | | ADMI NI STRATI VE & GENERAL | 5.00 | | 001.0 |
| 33.14 | PHYSI CI AN RECRUI TMENT | A | | ADULTS & PEDIATRICS | 30.00 | | 00 |
| 33.15 | PHYSI CLAN RECRUI TMENT | A | -30, 582 | | 93.00 | | 001.0 |
| 33. 16 | 340B REVENUE | A | -1, 476, 543 | | 15.00 | | 001.10 |
| 33. 17 | ER PURCHASED SVC/PROF FEE | A | | EMERGENCY | 91.00 | | 00.17 |
| 33. 18 | HAF OFFSET | A | -2, 032, 012 | ADMINISTRATIVE & GENERAL | 5.00 | | |
| 33. 19 | OTHER ADJUSTMENTS (SPECIFY) | | 0 | | 0.00 | 0 | 33.19 |
| ~~ ~~ | | | | | | | |
| 33.20 | OTHER ADJUSTMENTS (SPECIFY) | | 0 | | 0.00 | 0 | 33.20 |
| F0 00 | (3) TOTAL (sum of lines 1 thru 49) | | 11 107 400 | | | | F0 00 |
| 50.00 | (Transfer to Worksheet A, | | -11, 137, 438 | | | | 50.00 |
| | column 6, line 200.) | | | | | | |
| | | | | | | | |

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

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

| PROVI DE | R BASED PHYSICI | AN ADJUSTMENT | | Provider (| | Period: | Worksheet A-8 | 3-2 |
|----------|-----------------|-------------------------|----------------|----------------|--------------------|----------------------------------|------------------|--------|
| | | | | | | From 10/01/2017 To 09/30/2018 | Date/Time Pre | narod |
| | | | | | | 10 09/30/2010 | 2/28/2019 1:0 |)2 pm |
| | Wkst. A Line # | Cost Center/Physician | Total | Professi onal | Provi der | RCE Amount | Physi ci an/Prov | |
| | | Identifier | Remunerati on | Component | Component | | ider Component | |
| | | | | | | | Hours | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | 7.00 | |
| 1.00 | | ADULTS & PEDIATRICS | 424, 704 | 424, 704 | | - | 0 | 1.00 |
| 2.00 | | RADI OLOGY-DI AGNOSTI C | 62, 115 | | | | 0 | 2.00 |
| 3.00 | 93.000 | | 3, 001, 350 | | | | | 3.00 |
| 4.00 | | DPERATING ROOM | 859, 531 | 859, 521 | | | 0 | 4.00 |
| 5.00 | | RADI OLOGY-DI AGNOSTI C | 700, 134 | | | | 0 | 5.00 |
| 6.00 | 93.000 | | 841, 298 | | | 0 | 0 | 6.00 |
| 7.00 | | ADULTS & PEDIATRICS | 60, 032 | 60, 032 | C | 0 | 0 | 7.00 |
| 8.00 | 0.00 | | 0 | 0 | C | 0 | 0 | 8.00 |
| 9.00 | 0.00 | | 0 | 0 | C | 0 | 0 | 9.00 |
| 10.00 | 0.00 | | 0 | 0 | C | 0 | 0 | 10.00 |
| 200.00 | | | 5, 949, 164 | | | | 301 | 200.00 |
| | Wkst. A Line # | Cost Center/Physician | Unadjusted RCE | | Cost of | Provi der | Physician Cost | |
| | | Identifier | Limit | Unadjusted RCE | | | of Malpractice | |
| | | | | Limit | Continuing | Share of col. | Insurance | |
| | 1.00 | 2.00 | 8.00 | 9.00 | Education 12.00 | 12 13.00 | 14.00 | |
| 1.00 | | ADULTS & PEDIATRICS | 0.00 | 9.00 | | | 0 | 1.00 |
| 2.00 | | RADI OLOGY-DI AGNOSTI C | 0 | 0 | - | | 0 | 2.00 |
| 3.00 | 93.000 | | 25, 903 | - | | | 0 | 3.00 |
| 4.00 | | DPERATING ROOM | 23, 903 | 0 | | | 0 | 4.00 |
| 5.00 | | RADI OLOGY-DI AGNOSTI C | 0 | 0 | 0 | - | 0 | 5.00 |
| 6.00 | 93.000 | | 0 | 0 | 0 | , s | 0 | 6.00 |
| 7.00 | | ADULTS & PEDIATRICS | 0 | 0 | | 0 | 0 | 7.00 |
| 8.00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 8.00 |
| 9.00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 9.00 |
| 10.00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 10.00 |
| 200.00 | 01.00 | | 25, 903 | 1, 295 | 0 | 0 | 0 | |
| | 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 | | |
| 1.00 | | ADULTS & PEDIATRICS | 0 | 0 | - | | | 1.00 |
| 2.00 | | RADI OLOGY-DI AGNOSTI C | 0 | 0 | C | | | 2.00 |
| 3.00 | 93.000 | | 0 | 25, 903 | 19, 202 | | | 3.00 |
| 4.00 | | DPERATING ROOM | 0 | 0 | C | 859, 531 | | 4.00 |
| 5.00 | | RADI OLOGY-DI AGNOSTI C | 0 | 0 | C | | | 5.00 |
| 6.00 | 93.000 | | 0 | 0 | C | | | 6.00 |
| 7.00 | | ADULTS & PEDIATRICS | 0 | 0 | C | 00,002 | | 7.00 |
| 8.00 | 0.00 | | 0 | 0 | C | 0 | | 8.00 |
| 9.00 | 0.00 | | 0 | 0 | C | | | 9.00 |
| 10.00 | 0.00 | | 0 | | C | | | 10.00 |
| 200.00 | | | 0 | 25, 903 | 19, 202 | 5, 923, 261 | | 200.00 |
| | | | | | | | | |

FAYETTE REGIONAL HEALTH SYSTEM

In Lieu of Form CMS-2552-10

| Heal th | Financial Systems Fi | AYETTE REGIONAL | . HEALTH SYSTEM | | In Lie | eu of Form CMS- | 2552-10 |
|---------|---|---|---|------------------------------------|--|---|---------|
| COST A | LLOCATION - GENERAL SERVICE COSTS | | Provider C | | eriod: com 10/01/2017 o 09/30/2018 | Worksheet B Part I Date/Time Pre 2/28/2019 1:0 | epared: |
| | 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 | 2,081,629 | 2, 081, 629 | | | | 1.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 3, 556, 754 | 8, 271 | 3, 565, 025 | | | 4.00 |
| 5.00 | 00500 ADMINISTRATIVE & GENERAL | 7, 217, 722 | 133, 934 | 357, 814 | 7, 709, 470 | 7, 709, 470 | 5.00 |
| 7.00 | 00700 OPERATION OF PLANT | 1, 114, 432 | | 63, 116 | 2, 068, 389 | | |
| 7.01 | 00701 OPERATION OF PLANT | 970, 645 | | 0 | 970, 645 | | |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 110, 158 | | | 112, 710 | | |
| 9.00 | 00900 HOUSEKEEPI NG | 728, 431 | | | 840, 698 | | |
| | 01000 DI ETARY | 452, 730 | | | 512, 396 | | |
| | 01100 CAFETERIA | 312,049 | | | 387, 199 | | |
| | 01300 NURSI NG ADMI NI STRATI ON | 857, 325 | | | 993, 767 | | |
| | 01400 CENTRAL SERVICES & SUPPLY | 572, 274 | | | 601,002 | | |
| | 01500 PHARMACY | 2, 526, 913 | | | 2, 602, 219 | | |
| 16.00 | 01600 MEDI CAL RECORDS & LI BRARY | 1, 018, 113 | 20, 258 | 136, 301 | 1, 174, 672 | 262, 661 | 16.00 |
| 20.00 | INPATIENT ROUTINE SERVICE COST CENTERS | 2 144 000 | 110 027 | 272 255 | 2 527 101 | E(7.20) | 200.00 |
| | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT | 2, 144, 909 | | | 2, 537, 101 | | |
| | 04000 SUBPROVIDER - IPF | 1, 014, 063 329, 046 | | | 1, 201, 400 | | |
| | | | | | 391, 207 | | 1 |
| | 04100 SUBPROVIDER - IRF | 0 | 0 | 0 | 0 | 0 | |
| | 04200 SUBPROVI DER 04300 NURSERY | 370, 564 | 0 | 40,000 | 442 500 | 00 101 | |
| 43.00 | ANCI LLARY SERVI CE COST CENTERS | 370, 304 | 24, 235 | 48, 800 | 443, 599 | 99, 191 | 43.00 |
| 50.00 | 05000 OPERATING ROOM | 911, 556 | 128, 922 | 105, 642 | 1, 146, 120 | 256, 277 | 50.00 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 2, 777, 367 | | | 3, 106, 368 | | |
| | 06000 LABORATORY | 1, 912, 854 | | | 2, 072, 253 | | |
| | 06500 RESPI RATORY THERAPY | 499, 551 | | | 590, 680 | | |
| | 06600 PHYSI CAL THERAPY | 519, 863 | | | 641, 738 | | |
| | 06900 ELECTROCARDI OLOGY | 0 | 0 | 01,000 | 011,700 | 0 | 1 |
| | 06901 CARDI AC REHAB | 216, 178 | 15, 502 | 31, 644 | 263, 324 | | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 01,011 | 200, 021 | 00,000 | 1 |
| | 07200 I MPL. DEV. CHARGED TO PATIENTS | 291, 929 | 0 | 0 0 | 291, 929 | | |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | | 0 | . 0 | | 1 |
| | OUTPATIENT SERVICE COST CENTERS | - | | | | | 1 |
| 91.00 | 09100 EMERGENCY | 1, 602, 382 | 44, 239 | 222, 279 | 1, 868, 900 | 417, 894 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | 0 | | 92.00 |
| | 04050 CLI NI C | 3, 154, 922 | 134, 131 | 816, 550 | 4, 105, 603 | 918, 042 | 93.00 |
| | 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 | 1 | 1 | | | 1 | |
| | 09500 AMBULANCE SERVI CES | 0 | | | 0 | - | |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 0 | 0 | 0 | 0 | 101.00 |
| 11/ 00 | SPECIAL PURPOSE COST CENTERS | 0 | 0 | | | | 111 00 |
| 118.00 | 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) | 0 | | | 0 36, 633, 389 | | 116.00 |
| 118.00 | NONREIMBURSABLE COST CENTERS | 37, 264, 359 | 1, 895, 850 | 3, 119, 834 | 30, 033, 389 | 6, 467, 514 | 1118.00 |
| 100 00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | 0 | 0 | 190.00 |
| | 19100 RESEARCH | 0 | | | 0 | | 190.00 |
| | 19101 FMH DI AGNOSTI C CENTER | 103, 018 | | - | 117, 242 | | 191.00 |
| | 19102 WELLNESS | 230, 350 | | | 244, 808 | | 191.02 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 230, 330 | | | 33, 129 | | 191.02 |
| | 19201 RFE | 3, 655 | | | 3, 655 | | 192.00 |
| | 19202 MARKETI NG | 283, 518 | | 0 | 304, 648 | | 192.02 |
| | 19203 FOUNDATI ON | 0 | | | 7, 330 | | 192.03 |
| | 19206 HEART CENTER | 0 | | | 4, 902 | | 192.06 |
| | 19207 WVCP | 3, 589, 595 | | | 4, 086, 435 | | |
| | 19208 OCCUPATI ONAL MED | 667 | | | 4, 000, 400 | | 192.08 |
| | 19210 HOSPI TALI ST | 598, 955 | | - | 599, 900 | | |
| | 07950 OTHER NONREI MBURSABLE COST CENTERS | -15 | | | 50, 707 | | |
| | 07951 OTHER NONREI MBURSABLE COST CENTERS | 89,038 | | 11, 806 | 100, 844 | | |
| 200.00 | | ., 500 | l | , 200 | 000,011 | | 200.00 |
| 200.00 | | | n – | o | 0 | | 201.00 |
| 202.00 | | 42, 187, 656 | 2, 081, 629 | - | 42, 187, 656 | | |
| 20 | | , | ,,, | | ,, 500 | | |
| | | | | | | | |

| COST # | Financial Systems FA | | Provider CO | CN: 15-0064 | Period: From 10/01/2017 | u of Form CMS-2 Worksheet B Part I Date/Time Pre 2/28/2019 1:0 | pared: |
|----------------|---|--------------------|--------------------|-----------------------|----------------------------|--|------------------|
| | Cost Center Description | OPERATION OF | OPERATI ON OF | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | [|
| | | PLANT 7.00 | PLANT 7. 01 | LINEN SERVICE 8.00 | 9.00 | 10.00 | |
| | GENERAL SERVICE COST CENTERS | 7.00 | 7.01 | 0.00 | 9.00 | 10.00 | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5.00 | 00500 ADMINI STRATI VE & GENERAL | | | | | | 5.00 |
| 7.00 | 00700 OPERATION OF PLANT | 2, 530, 889 | | | | | 7.00 |
| 7.01 | 00701 OPERATION OF PLANT | 0 | 1, 187, 685 | | | | 7.01 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 5, 895 | 4,020 | 147, 82 | | | 8.00 |
| 9.00 | 00900 HOUSEKEEPI NG 01000 DI ETARY | 24, 264 | | 15 02 | 0 1,069,494 | 714 714 | 9.00 |
| 10.00 11.00 | 01100 CAFETERI A | 33, 893 49, 188 | 23, 116 33, 548 | 15, 93 | 3 14,802 0 21,483 | 714, 714 0 | 10.00 |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 49,100 | 0 | | 0 21,403 | 0 | 1 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 32, 260 | 22, 002 | | 14,089 | 0 | |
| 15.00 | 01500 PHARMACY | 31, 215 | | | 13, 633 | 0 | 1 |
| 16.00 | 01600 MEDI CAL RECORDS & LI BRARY | 46, 787 | 31, 910 | | 20, 434 | 0 | |
| | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 274, 456 | 187, 187 | 37, 50 | 4 119, 867 | 277, 100 | 30.00 |
| 31.00 | 03100 I NTENSI VE CARE UNI T | 111, 547 | 76, 078 | 13, 67 | | 63, 473 | |
| 40.00 | 04000 SUBPROVI DER – I PF | 94, 787 | 0 | (| 0 41, 398 | 9, 578 | |
| 41.00 | 04100 SUBPROVIDER - IRF | 0 | 0 | (| 0 0 | 0 | |
| 42.00 | 04200 SUBPROVI DER | 0 | 0 | (| 0 0 | 0 | |
| 43.00 | | 55, 972 | 38, 174 | (| 24, 445 | 0 | 43.00 |
| | ANCI LLARY SERVICE COST CENTERS | 297, 747 | 203, 072 | 12 40 | 130, 039 | 0 | |
| 50.00 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 264, 947 | 180, 701 | 13, 40 19, 86 | | 0 | |
| 60.00 | 06000 LABORATORY | 85, 722 | 58, 465 | | 37, 439 | 0 | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 43, 053 | 29, 364 | | 18,803 | 0 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 93, 178 | | 17, 04 | | 0 | 66.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | (| 0 0 | 0 | 69.00 |
| 69. 01 | 06901 CARDI AC REHAB | 35, 802 | 24, 418 | 1, 250 | 0 15, 636 | 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 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 0 | 0 | 73.00 |
| 01 00 | | 100 171 | (0.(0) | 2(20) | 44 (22) | 20 472 | 01 00 |
| 91.00 92.00 | 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 102, 171 | 69, 683 | 26, 20 | 8 44, 622 | 30, 472 | 91.00 92.00 |
| 92.00 | 04050 CLINIC | 309, 779 | 64, 467 | 9: | 3 135, 294 | 0 | 1 |
| 93.00 | 04950 BI C | 0 | 04,407 | | 0 0 | 0 | |
| 93.05 | 04954 PODI ATRY | 0 | 0 | | | 0 | |
| | OTHER REIMBURSABLE COST CENTERS | | | | 1 | | |
| 95.00 | 09500 AMBULANCE SERVI CES | 0 | 0 | (| 0 0 | 0 | 95.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 0 | (| 0 0 | 0 | 101.00 |
| | SPECIAL PURPOSE COST CENTERS | 1 | | | | | |
| | 11600 HOSPI CE | 0 | 0 | | 0 0 | | 116.00 |
| 118.00 | | 1, 992, 663 | 1, 147, 594 | 144, 96 | 6 857, 111 | 380, 623 | 1118.00 |
| 100.00 | NONREI MBURSABLE COST CENTERS | 0 | 0 | | | 0 | 100.00 |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | | | | 190.00 |
| | 19100 RESEARCH | 0 | | | | | 191.00 191.01 |
| | 2 19102 WELLNESS | 109, 170 | | | 47,679 | | 191.02 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 14, 863 | | 2, 38 | | 334, 091 | |
| | 19201 RFE | 0 | 0 | 2,00 | 0 0 | | 192.01 |
| | 19202 MARKETI NG | 15, 668 | 10, 686 | (| 6, 843 | | 192.02 |
| | 19203 FOUNDATI ON | 16, 928 | | (| 7, 393 | | 192.03 |
| | 19206 HEART CENTER | 11, 322 | | (| 0 4, 945 | | 192.06 |
| | 19207 WVCP | 253, 133 | 0 | 47 | 9 108, 777 | | 192.07 |
| | 19208 OCCUPATIONAL MED | 0 | 0 | (| 0 0 | | 192.08 |
| | | 0 | 0 | | 0 0 | | 192.10 |
| | 07950 OTHER NONRELMBURSABLE COST CENTERS | 117, 142 | 0 | | 30, 255 | | 194.00 |
| | 07951 OTHER NONREI MBURSABLE COST CENTERS | 0 | 0 | | 0 | 0 | 194.01 |
| 200.00 | 5 | _ | _ | | | 0 | 200.00 |
| | Inegative cost cellers | 0 | 0 | | - U | | |
| 202.00 |) TOTAL (sum lines 118 through 201) | 2, 530, 889 | 1, 187, 685 | 147, 82 | 7 1, 069, 494 | 714, 714 | 1202 00 |

| CUST | ALLOCATION - GENERAL SERVICE COSTS | | Provider CC | | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I Date/Time Pre 2/28/2019 1:0 | epared:)2 pm |
|----------------|---|--------------------|---|---------------------------------|---|---|------------------|
| | Cost Center Description | CAFETERI A | NURSI NG ADMI NI STRATI ON | CENTRAL SERVICES & SUPPLY | PHARMACY | MEDI CAL RECORDS & LI BRARY | |
| | | 11.00 | 13.00 | 14.00 | 15.00 | 16.00 | |
| 1 00 | GENERAL SERVICE COST CENTERS | | | | | | 1 1 00 |
| 1.00 4.00 | 00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 1.00 |
| 4.00 5.00 | 00500 ADMINISTRATIVE & GENERAL | | | | | | 4.00 5.00 |
| 7.00 | 00700 OPERATION OF PLANT | | | | | | 7.00 |
| 7.00 | 00701 OPERATION OF PLANT | | | | | | 7.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| 9.00 | 00900 HOUSEKEEPI NG | | | | | | 9.00 |
| 10.00 | 01000 DI ETARY | | | | | | 10.00 |
| 11.00 | 01100 CAFETERI A | 577, 997 | | | | | 11.00 |
| 13.00 | 01300 NURSING ADMINISTRATION | 0 | 1, 215, 977 | | | | 13.00 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 0 | 0 | 803, 73 | | | 14.00 |
| 15.00 | 01500 PHARMACY | 0 | 0 | | 0 3, 250, 224 | | 15.00 |
| 16.00 | 01600 MEDI CAL RECORDS & LI BRARY | 24, 134 | 0 | | 0 0 | 1, 560, 598 | 16.00 |
| 20.00 | INPATIENT ROUTINE SERVICE COST CENTERS | 44 410 | E2 0(0 | | | 105 272 | 20.00 |
| 30.00 31.00 | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT | 46, 418 31, 573 | | | 0 0 0 0 | 105, 372 19, 875 | |
| 40.00 | 04000 SUBPROVIDER - IPF | 6, 581 | 0 | | 0 0 | 5, 495 | 1 |
| 41.00 | 04100 SUBPROVI DER – I RF | 0, 301 | , i i i i i i i i i i i i i i i i i i i | | 0 0 | 5,495 | |
| 42.00 | 04200 SUBPROVI DER | 0 | 0 | | 0 0 | 0 | 1 |
| 43.00 | 04300 NURSERY | 8, 452 | 0 | | 0 0 | 6, 768 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | · · · | 1 |
| 50.00 | 05000 OPERATI NG ROOM | 23, 660 | 105, 737 | | 0 0 | 79, 729 | 50.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 44, 348 | | | 0 0 | 438, 726 | 1 |
| 60.00 | 06000 LABORATORY | 33, 535 | | | 0 0 | 274, 910 | 1 |
| 65.00 | 06500 RESPI RATORY THERAPY | 17,470 | | | 0 0 | 59, 964 | 1 |
| 66.00 | 06600 PHYSI CAL THERAPY | 17,841 | | | 0 0 | 26, 619 | 1 |
| 69.00 69.01 | 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB | 8, 189 0 | 42, 295 0 | | 0 0 | 0 7,633 | |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 133, 267 | 0 | 803, 73 | - | 26, 765 | 1 |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 133, 207 | - | | 0 0 | 11, 194 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | | | 0 3, 250, 224 | 156, 099 | |
| | OUTPATIENT SERVICE COST CENTERS | | 1 | | | | |
| 91.00 | 09100 EMERGENCY | 45, 910 | 211, 474 | | 0 0 | 248, 440 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| 93.00 | 04050 CLI NI C | 0 | 285, 489 | | 0 0 | 92, 966 | |
| 93.01 | 04950 BI C | 0 | 0 | | 0 0 | 43 | |
| 93.05 | | 0 | 0 | | 0 0 | 0 | 93.05 |
| 05 00 | OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES | 0 | 0 | | 0 0 | 0 | 95.00 |
| | 10100 HOME HEALTH AGENCY | 0 | | | 0 0 | | 101.00 |
| 101.00 | SPECIAL PURPOSE COST CENTERS | 0 | <u>ч</u> | | | 0 | |
| 116.00 | 11600 HOSPI CE | 0 | 0 | | 0 0 | 0 | 116.00 |
| 118.00 | | 441, 378 | 1, 215, 977 | 803, 73 | 9 3, 250, 224 | 1, 560, 598 | |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | | | 0 0 | | 190.00 |
| | 19100 RESEARCH | 0 | - | | 0 0 | | 191.00 |
| | 19101 FMH DIAGNOSTIC CENTER | 0 | 0 | | 0 0 | | 191.01 |
| | 19102 WELLNESS | 7,002 | | | 0 0 | | 191.02 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 5, 147 | 0 | | 0 0 | | 192.00 192.01 |
| | 19201 RFE 219202 MARKETI NG | 0 | 0 | | 0 0 | | 192.01 |
| | 19202 MARKETTING 19203 FOUNDATION | 0 | 0 | | | | 192.02 |
| | 19206 HEART CENTER | 0 | 0 | | 0 0 | | 192.06 |
| | 19207 WVCP | 124, 372 | 0 | | 0 0 | | 192.07 |
| | 19208 OCCUPATIONAL MED | 0 | 0 0 | | 0 0 | | 192.08 |
| | 19210 HOSPI TALI ST | 98 | o | | 0 0 | | 192.10 |
| | 07950 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | | 0 0 | | 194.00 |
| | 07951 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | | 0 0 | 0 | 194.01 |
| 200.00 | | | | | | | 200.00 |
| | | | | | ~ ~ ~ | 0 | 201.00 |
| 201.00 | | 0 577, 997 | 0 1, 215, 977 | 803, 73 | 0 0 9 3, 250, 224 | | |

| COST / | ALLOCATION - GENERAL SERVICE COSTS | | Provider CC | N: 15-0064 | Period: Workshe From 10/01/2017 Part I | et B |
|--|---|--|---|---|--|--|
| | | | | | To 09/30/2018 Date/Ti | me Prepared: 19 1:02 pm |
| | Cost Center Description | Subtotal | Intern & Residents Cost & Post Stepdown Adjustments | Total | | 19 1. 02 pm |
| | | 24.00 | 25.00 | 26.00 | | |
| 1. 00 4. 00 5. 00 7. 01 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | 1.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0 15.0 16.0 |
| 30.00 31.00 40.00 41.00 42.00 43.00 | 03100 I NTENSI VE CARE UNI T | 4, 205, 18(1, 834, 97 636, 52 (676, 60 | 7 0 1 0 0 0 0 0 | 4, 205, 1 1, 834, 9 636, 5 676, 6 | 77 21 0 0 | 30. 0 31. 0 40. 0 41. 0 42. 0 43. 0 |
| 50. 00 54. 00 60. 00 65. 00 66. 00 69. 00 69. 01 71. 00 72. 00 73. 00 | 05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS | 2, 255, 78 5, 066, 163 3, 173, 720 976, 002 1, 128, 74 50, 48 406, 94 963, 77 368, 399 3, 406, 323 | 3 0 2 0 7 0 4 0 3 0 1 0 9 0 | 2, 255, 7 5, 066, 1 3, 173, 7 976, 0 1, 128, 7 50, 4 406, 9 963, 7 368, 3 3, 406, 3 | 63 20 02 47 84 43 71 99 | 50.0 54.0 60.0 65.0 66.0 69.0 69.0 71.0 72.0 73.0 |
| 91.00 92.00 93.00 93.01 93.05 | 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) | 3, 065, 774 5, 911, 73; 4; (| 0 3 0 3 0 | 3, 065, 7 5, 911, 7 | | 91. 0 92. 0 93. 0 93. 0 93. 0 |
| 95.00 101.00 | 10100 HOME HEALTH AGENCY | (| 0 0 0 0 | | 0 0 | 95. 0 101. 0 |
| 116.00 118.00 | SPECIAL PURPOSE COST CENTERS 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS | (34, 127, 162 | - | 34, 127, 1 | 0 62 | 116. 0 118. 0 |
| 191. 0 191. 0 191. 0 192. 0 192. 0 192. 0 192. 0 192. 0 192. 0 192. 0 192. 1 192. 1 192. 1 192. 1 | Negative Cost Centers | (143, 458 463, 399 413, 644 4, 472 405, 966 44, 83 29, 98 5, 486, 933 810 734, 138 209, 442 123, 392 (42, 187, 656 | D O 3 O 3 O 3 O 2 O 5 O 6 O 7 O 6 O 7 O 6 O 7 O 6 O 7 O 6 O 7 O 6 O 7 O 6 O 7 O 9 O 0 O 0 O | 143, 4 463, 3 413, 6 4, 4 405, 9 44, 8 29, 9 5, 486, 9 5, 486, 9 8 734, 1 209, 4 123, 3 42, 187, 6 | 99 48 72 66 36 87 39 16 38 42 93 0 0 | 190. 0 191. 0 191. 0 192. 0 200. 0 201. 0 202. 0 |

| Heal th | Fi nanci al | | Syste | ems | |
|---------|-------------|--|-------|---------|----|
| | | | | PELATED | CC |

FAYETTE REGIONAL HEALTH SYSTEM

In Lieu of Form CMS-2552-10

| | | AYETTE REGIONAL | | | | u of Form CMS- | 2552-10 |
|----------------|---|--|---|-------------|--|--|------------------|
| ALLOCA | TION OF CAPITAL RELATED COSTS | | Provider C | | eriod: rom 10/01/2017 o 09/30/2018 | Worksheet B Part II Date/Time Pre 2/28/2019 1:0 | |
| | Cost Center Description | Directly Assigned New Capital Related Costs | CAPI TAL RELATED COSTS BLDG & FI XT | Subtotal | EMPLOYEE BENEFI TS DEPARTMENT | ADMI NI STRATI VE & GENERAL | |
| | | 0 | 1.00 | 2A | 4.00 | 5.00 | |
| | GENERAL SERVICE COST CENTERS | | | | | - | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | 0.074 | 0.074 | 0.074 | | 1.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 0 | | | 8, 271 | | 4.00 |
| 5.00 7.00 | 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT | 0 | 133, 934 890, 841 | | 831 147 | | |
| 7.00 | 00701 OPERATION OF PLANT | 0 | 0,041 | | 0 | | 1 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 0 | - | - | 0 | | |
| 9.00 | 00900 HOUSEKEEPI NG | 0 | 10, 506 | | 236 | | 1 |
| 10.00 | 01000 DI ETARY | 0 | 14, 675 | 14, 675 | 104 | 2, 003 | 10.00 |
| 11.00 | 01100 CAFETERI A | 0 | 21, 298 | 21, 298 | 125 | 1, 514 | 11.00 |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 0 | - | - | 317 | | |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 0 | | | 34 | | |
| 15.00 | 01500 PHARMACY | 0 | | | 143 | | |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS | 0 | 20, 258 | 20, 258 | 316 | 4, 592 | 16.00 |
| 30.00 | 03000 ADULTS & PEDIATRICS | 0 | 118, 837 | 118, 837 | 635 | 9, 918 | 30.00 |
| 31.00 | 03100 I NTENSI VE CARE UNI T | 0 | | | 323 | | |
| 40.00 | 04000 SUBPROVIDER - IPF | 0 | | | 49 | | |
| 41.00 | 04100 SUBPROVI DER – I RF | 0 | 0 | 0 | 0 | 0 | 41.00 |
| 42.00 | 04200 SUBPROVI DER | 0 | | 0 | 0 | | 42.00 |
| 43.00 | 04300 NURSERY | 0 | 24, 235 | 24, 235 | 113 | 1, 734 | 43.00 |
| 50.00 | ANCI LLARY SERVICE COST CENTERS | | 100.000 | 100.000 | 0.45 | 4 400 | 50.00 |
| 50.00 54.00 | 05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C | 0 | | | 245 497 | | |
| 60. 00 | 06000 LABORATORY | 0 | | | 284 | | |
| 65.00 | 06500 RESPIRATORY THERAPY | 0 | 18, 642 | | 168 | | |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | | | 189 | | |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | 0 | 0 | | |
| 69.01 | 06901 CARDI AC REHAB | 0 | 15, 502 | 15, 502 | 73 | 1, 029 | 69.01 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | - | - | 0 | | |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | | - | 0 | | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 73.00 |
| 91.00 | 09100 EMERGENCY | 0 | 44, 239 | 44, 239 | 516 | 7, 306 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 11,207 | 0 | 010 | , | 92.00 |
| 93.00 | 04050 CLI NI C | 0 | 134, 131 | 134, 131 | 1, 893 | 16, 038 | |
| 93.01 | 04950 BI C | 0 | 0 | 0 | 0 | 0 | 93.01 |
| 93.05 | 04954 PODI ATRY | 0 | 0 | 0 | 0 | 0 | 93.05 |
| 05 00 | OTHER REIMBURSABLE COST CENTERS | | | | Ō | | 05 00 |
| | 09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY | 0 | | | 0 | | 95.00 |
| 101.00 | SPECIAL PURPOSE COST CENTERS | 0 | 0 | 0 | 0 | 0 | |
| 116.00 | 11600 HOSPI CE | 0 | 0 | 0 | 0 | 0 | 116.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 0 | 1, 895, 850 | 1, 895, 850 | 7, 238 | 113, 053 | 118.00 |
| | NONREI MBURSABLE COST CENTERS | 1 | 1 | | | | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | - | - | 0 | | 190.00 |
| | 19100 RESEARCH | 0 | - | | 0 | | 191.00 |
| | 19101 FMH DIAGNOSTIC CENTER 19102 WELLNESS | 0 | 0 | - | 33 34 | | 191.01 |
| | 19102 WELLNESS 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | - | - | 5 | | 191.02 |
| | 19201 RFE | 0 | 0, 430 | 0, 430 | 0 | | 192.00 |
| | 19202 MARKETI NG | 0 | 6, 784 | - | 33 | | 192.02 |
| | 19203 FOUNDATI ON | 0 | 7, 330 | 7, 330 | 0 | | 192.03 |
| | 19206 HEART CENTER | 0 | 4, 902 | 4, 902 | | | 192.06 |
| | 19207 WVCP | 0 | | | 899 | | 192.07 |
| | 19208 OCCUPATIONAL MED | 0 | - | | 0 | | 192.08 |
| | 19210 HOSPITALIST 07950 OTHER NONREIMBURSABLE COST CENTERS | 0 | - | - | 2 | | 192.10 194.00 |
| | 07950 OTHER NONREIMBURSABLE COST CENTERS | 0 | | 50, 722 | 27 | | 194.00 |
| 200.00 | | 0 | | 0 | 27 | 394 | 200.00 |
| 201.00 | | | 0 | 0 | 0 | о | 201.00 |
| 202.00 | | 0 | 2, 081, 629 | 2, 081, 629 | 8, 271 | | |
| | | | | | | | |

| LOCA | Financial Systems Fi TION OF CAPITAL RELATED COSTS | | Provider CC | CN: 15-0064 P | eriod: | Worksheet B | |
|-------|--|-----------------------|-----------------------|----------------------------|--------------------------------|---|------------|
| | | | | | rom 10/01/2017 o 09/30/2018 | Part II Date/Time Pre 2/28/2019 1:0 | epare |
| | 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 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4. |
| 00 | 00500 ADMINI STRATI VE & GENERAL | | | | | | 5 |
| 00 | 00700 OPERATION OF PLANT | 899, 073 | | | | | 7 |
| 01 | 00701 OPERATION OF PLANT | 0 | 3, 794 | | | | 7 |
| 00 | 00800 LAUNDRY & LINEN SERVICE | 2,094 | 13 | 5, 100 | | | 8 |
| 0C | 00900 HOUSEKEEPI NG | 8, 620 | 53 | 0 | 22, 701 | | 9 |
| . 00 | 01000 DI ETARY | 12,040 | 74 | 550 | 314 | 29, 760 | 10 |
| . 00 | 01100 CAFETERI A | 17, 474 | 107 | 0 | 456 | 0 | 11 |
| . 00 | 01300 NURSI NG ADMI NI STRATI ON | 0 | 0 | 0 | 0 | 0 | 13 |
| . 00 | 01400 CENTRAL SERVICES & SUPPLY | 11, 460 | 70 | 0 | 299 | 0 | 14 |
| . 00 | 01500 PHARMACY | 11,089 | 68 | 0 | 289 | 0 | 15 |
| . 00 | 01600 MEDICAL RECORDS & LIBRARY | 16, 621 | 102 | 0 | 434 | 0 | 16 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| . 00 | 03000 ADULTS & PEDI ATRI CS | 97, 498 | 598 | 1, 294 | 2, 544 | 11, 538 | 30 |
| . 00 | 03100 I NTENSI VE CARE UNI T | 39, 626 | | 472 | | 2, 643 | |
| 00 | 04000 SUBPROVIDER - IPF | 33, 672 | 0 | 0 | | 399 | |
| . 00 | 04100 SUBPROVI DER – I RF | 00,072 | 0 | 0 | 0 | 0 | |
| . 00 | 04200 SUBPROVI DER | 0 | 0 | 0 | 0 | 0 | |
| . 00 | 04300 NURSERY | 19, 883 | 122 | 0 | | 0 | |
| . 00 | ANCI LLARY SERVI CE COST CENTERS | 17,003 | 122 | 0 | 517 | 0 | 1 - 3 |
| . 00 | 05000 OPERATING ROOM | 105, 772 | 648 | 462 | 2, 760 | 0 | 50 |
| . 00 | 05400 RADI OLOGY-DI AGNOSTI C | 94, 120 | | 685 | | 0 | |
| . 00 | 06000 LABORATORY | 30, 452 | 187 | 000 | | 0 | |
| . 00 | 06500 RESPI RATORY THERAPY | 15, 294 | 94 | 0 | | 0 | |
| . 00 | 06600 PHYSI CAL THERAPY | | 203 | 588 | | 0 | |
| . 00 | | 33, 101 | 203 | 0 | | 0 | |
| | | - | | | | | |
| . 01 | 06901 CARDI AC REHAB | 12, 718 | 78 | 43 | | 0 | |
| . 00 | 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0 | | 0 | |
| . 00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | 0 | 0 | | 0 | |
| . 00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 73 |
| . 00 | OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY | 24 205 | 223 | 904 | 947 | 1, 269 | 91 |
| | | 36, 295 | 223 | 904 | 947 | 1, 209 | |
| . 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 110 042 | 20/ | 2 | 2,072 | 0 | 92 |
| . 00 | 04050 CLINIC | 110, 043 | | 3 | | 0 | |
| . 01 | 04950 BI C | 0 | 0 | 0 | | 0 | |
| . 05 | 04954 PODI ATRY | 0 | 0 | 0 | 0 | 0 | 93 |
| 00 | OTHER REIMBURSABLE COST CENTERS | 0 | 0 | 0 | | 0 | |
| | 09500 AMBULANCE SERVICES | 0 | | 0 | | 0 | |
| 1.00 | 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 101 |
| | | 0 | 0 | 0 | | 0 | 111/ |
| | 11600 HOSPICE | | | | | | 116 |
| 8.00 | SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS | 707, 872 | 3, 666 | 5, 001 | 18, 193 | 15, 849 | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | 0 | Ō | 190 |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | | | |
| | | 0 | | 0 | | | 191 |
| | 19101 FMH DIAGNOSTIC CENTER | | 0 | 0 | | | 191 |
| | | 38, 782 | 0 | 0 | | | 191 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 5, 280 | | 82 | | 13, 911 | |
| | 19201 RFE | 0 | 0 | 0 | | | 192 |
| | 19202 MARKETI NG | 5, 566 | | 0 | | | 192 |
| | 19203 FOUNDATI ON | 6, 014 | | 0 | | | 192 |
| | 19206 HEART CENTER | 4, 022 | | 0 | | | 192 |
| | 19207 WVCP | 89, 923 | 0 | 17 | | | 192 |
| | 19208 OCCUPATIONAL MED | 0 | 0 | 0 | - | | 192 |
| | 19210 HOSPI TALI ST | 0 | 0 | 0 | 0 | | 192 |
| 1 00 | 07950 OTHER NONREI MBURSABLE COST CENTERS | 41, 614 | 0 | 0 | 642 | | 194 |
| | 07951 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 194 |
| | 07751 OTHER NONKET MOORSABLE COST CENTERS | | | | | | 1 |
| | | | | | | | 200 |
| 4. O´ | Cross Foot Adjustments | 0 | 0 | 0 | 0 | 0 | 200 201 |

| | | AYETTE REGIONAL | | | | u of Form CMS- | 2552-10 |
|----------------|--|-----------------|-------------------------------|----------------------------------|---|--|--------------------|
| ALLOCA | TION OF CAPITAL RELATED COSTS | | Provider CC | F | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Pre 2/28/2019 1:0 | epared: |
| | Cost Center Description | CAFETERI A | NURSI NG ADMI NI STRATI ON | CENTRAL SERVI CES & SUPPLY | PHARMACY | MEDI CAL RECORDS & LI BRARY | pm |
| | | 11.00 | 13.00 | 14.00 | 15.00 | 16.00 | |
| 1 00 | GENERAL SERVICE COST CENTERS | | | | 1 | | 1 1 00 |
| 1.00 4.00 | 00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 1.00 |
| 5.00 | 00500 ADMINI STRATI VE & 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 | 01000 DI ETARY | | | | | | 10.00 |
| 11.00 | | 40, 974 | | | | | 11.00 |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 0 | 4, 202 | 20, 100 | | | 13.00 |
| 14.00 15.00 | 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY | 0 | 0 | 28, 180 (| | | 14.00 15.00 |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | 1, 711 | 0 | (| | 44, 034 | |
| 10.00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 1,711 | <u>ч</u> | | , | | 10.00 |
| 30.00 | 03000 ADULTS & PEDIATRICS | 3, 291 | 183 | (| 0 0 | 2, 975 | 30.00 |
| 31.00 | 03100 I NTENSI VE CARE UNI T | 2, 238 | 0 | (| 0 | 561 | |
| 40.00 | 04000 SUBPROVI DER – I PF | 467 | 0 | (| 0 0 | 155 | 40.00 |
| 41.00 | 04100 SUBPROVI DER – I RF | 0 | 0 | (| 0 0 | 0 | 41.00 |
| 42.00 | 04200 SUBPROVI DER | 0 | 0 | (| - | 0 | |
| 43.00 | | 599 | 0 | (| 0 0 | 191 | 43.00 |
| 50, 00 | ANCI LLARY SERVICE COST CENTERS | 1,677 | 365 | | 0 | 2, 251 | 50.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 3, 144 | | (| | 12, 361 | |
| 60.00 | 06000 LABORATORY | 2, 377 | | (| | 7, 761 | |
| 65.00 | 06500 RESPIRATORY THERAPY | 1, 238 | | (| 0 | 1, 693 | |
| 66.00 | 06600 PHYSI CAL THERAPY | 1, 265 | | (| 0 | 752 | 66.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 581 | 146 | (| 0 0 | 0 | 69.00 |
| 69.01 | 06901 CARDI AC REHAB | 0 | - | (| | 215 | |
| 71.00 | 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 9,446 | | 28, 180 | | 756 | |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | | (| | 316 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS | 0 | <u> </u> | (| 35, 277 | 4, 407 | 73.00 |
| 91.00 | 09100 EMERGENCY | 3, 255 | 731 | (| 0 | 7, 014 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0,200 | , | | | ,, | 92.00 |
| 93.00 | 04050 CLINIC | 0 | 987 | (| 0 | 2, 625 | 93.00 |
| 93.01 | 04950 BI C | 0 | 0 | (| | 1 | 93.01 |
| 93.05 | 04954 PODI ATRY | 0 | 0 | (| 0 0 | 0 | 93.05 |
| 05 00 | | 0 | | | | | 05 00 |
| 95.00 | 09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY | 0 | | (| | 0 | 95.00 101.00 |
| 101.00 | SPECIAL PURPOSE COST CENTERS | 0 | UU | | <u> </u> | 0 | 101.00 |
| 116.00 | 11600 HOSPI CE | 0 | 0 | (| 0 0 | 0 | 116.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 31, 289 | 4, 202 | 28, 180 | 35, 277 | 44, 034 | 118.00 |
| | NONREI MBURSABLE COST CENTERS | 1 | | | 1 1 | | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | (| | | 190.00 |
| | 19100 RESEARCH | 0 | | (| | | 191.00 |
| | 19101 FMH DIAGNOSTIC CENTER 19102 WELLNESS | 0 496 | | (| - | | 191. 01 191. 02 |
| | 19102 WELENESS 19200 PHYSICIANS' PRIVATE OFFICES | 365 | | (| | | 192.00 |
| | 19201 RFE | 0 | 0 | (| | | 192.00 |
| | 19202 MARKETI NG | 0 | o o | (| 0 | | 192.02 |
| 192.03 | 19203 FOUNDATI ON | 0 | 0 | (| 0 | | 192. 03 |
| | 19206 HEART CENTER | 0 | 0 | (| 0 0 | | 192.06 |
| | 19207 WVCP | 8, 817 | 0 | (| 0 | | 192. 07 |
| | 19208 OCCUPATI ONAL MED | 0 | 0 | (| 0 | | 192.08 |
| | 19210 HOSPI TALI ST | 7 | 0 | (| 0 | | 192.10 |
| | 07950 OTHER NONREIMBURSABLE COST CENTERS 07951 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | (| | | 194.00 194.01 |
| 200.00 | | 0 | | (| | 0 | 200.00 |
| 201.00 | | 0 | о | (| 0 | 0 | 201.00 |
| 202.00 | 0 | 40, 974 | 4, 202 | 28, 180 | 35, 277 | | 202.00 |
| | | | | | | | |

| Heal th | Fina | inci | al | Syste | ems | | |
|---------|------|------|-----|-------|-----|------|----|
| | | OF | CAL | | DEL | ATED | CC |

FAYETTE REGIONAL HEALTH SYSTEM

In Lieu of Form CMS-2552-10

| | Financial Systems Fi TION OF CAPITAL RELATED COSTS | AYETTE REGIONAL | Provider CC | N: 15-0064 | In Lieu of Form (Period: Worksheet | |
|----------------|---|----------------------|---|--------------------|---|----------------------|
| | | | | | From 10/01/2017 Part II To 09/30/2018 Date/Time 2/28/2019 | Prepared: 1:02 pm |
| | Cost Center Description | Subtotal | Intern & Residents Cost & Post Stepdown Adjustments | Total | | |
| | | 24.00 | 25.00 | 26.00 | | |
| | GENERAL SERVICE COST CENTERS | | | | - | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | 1.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | 4.00 |
| 5.00 | 00500 ADMINI STRATI VE & 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 10.00 | 00900 HOUSEKEEPI NG 01000 DI ETARY | | | | | 9.00 |
| 10.00 | 01100 CAFETERIA | | | | | 10.00 |
| | 01300 NURSI NG ADMI NI STRATI ON | | | | | 13.00 |
| | 01400 CENTRAL SERVICES & SUPPLY | | | | | 14.00 |
| 15.00 | 01500 PHARMACY | | | | | 15.00 |
| | 01600 MEDI CAL RECORDS & LI BRARY | | | | | 16.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | 1 | II | | | |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | 249, 311 | 0 | 249, 31 | 1 | 30.00 |
| 31.00 | 03100 INTENSIVE CARE UNIT | 100, 135 | 0 | 100, 13 | 5 | 31.00 |
| | 04000 SUBPROVIDER - IPF | 78, 192 | 0 | 78, 19 | 2 | 40.00 |
| | 04100 SUBPROVI DER – I RF | 0 | 0 | | 0 | 41.00 |
| 42.00 | 04200 SUBPROVI DER | 0 | 0 | | 0 | 42.00 |
| 43.00 | 04300 NURSERY | 47, 396 | 0 | 47, 39 | 6 | 43.00 |
| | ANCI LLARY SERVI CE COST CENTERS | 247 502 | 0 | 247 50 | 2 | F0.00 |
| 50.00 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 247, 582 241, 397 | 0 | 247, 58 241, 39 | | 50.00 54.00 |
| 60.00 | 06000 LABORATORY | 87, 585 | 0 | 87, 58 | | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 40, 129 | 0 | 40, 12 | | 65.00 |
| | 06600 PHYSI CAL THERAPY | 80, 108 | 0 | 80, 10 | | 66.00 |
| | 06900 ELECTROCARDI OLOGY | 727 | 0 | 72 | | 69.00 |
| 69.01 | 06901 CARDI AC REHAB | 29, 990 | 0 | 29, 99 | 0 | 69.01 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 38, 382 | 0 | 38, 38 | 2 | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 1, 457 | 0 | 1, 45 | | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 39, 684 | 0 | 39, 68 | 4 | 73.00 |
| 91.00 | OUTPATIENT SERVICE COST CENTERS | 102, 699 | 0 | 102, 69 | 0 | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 102,099 | 0 | 102, 09 | 7 | 92.00 |
| | 04050 CLINIC | 268, 798 | 0 | 268, 79 | 8 | 93.00 |
| | 04950 BI C | 1 | 0 | | 1 | 93.01 |
| 93.05 | 04954 PODI ATRY | 0 | 0 | | 0 | 93.05 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | |
| | 09500 AMBULANCE SERVICES | 0 | | | 0 | 95.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 0 | | 0 | 101.00 |
| 114 00 | SPECIAL PURPOSE COST CENTERS 11600 HOSPICE | 0 | 0 | | 0 | 116.00 |
| 118.00 | | 1, 653, 573 | | 1, 653, 57 | | 118.00 |
| 110.00 | NONREI MBURSABLE COST CENTERS | 1,000,070 | <u> </u> | 1,000,07 | 5 | 110.00 |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | | 0 | 190.00 |
| 191.00 | 19100 RESEARCH | 0 | 0 | | 0 | 191.00 |
| 191.01 | 19101 FMH DIAGNOSTIC CENTER | 491 | 0 | 49 | 1 | 191.01 |
| | 19102 WELLNESS | 41, 281 | 0 | 41, 28 | | 191.02 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 26, 379 | 0 | 26, 37 | | 192.00 |
| | 19201 RFE | 14 | 0 | 10.75 | | 192.01 |
| | 19202 MARKETI NG 19203 FOUNDATI ON | 13, 753 | | 13, 75 13, 56 | | 192.02 192.03 |
| | 19206 HEART CENTER | 13, 567 9, 073 | | 9, 07 | | 192.03 |
| | 19207 WVCP | 227, 544 | 0 | , 07 227, 54 | | 192.00 |
| | 19208 OCCUPATI ONAL MED | 3 | 0 | 227, 34 | 3 | 192.08 |
| | 19210 HOSPI TALI ST | 2, 354 | 0 | 2, 35 | 4 | 192.10 |
| | 07950 OTHER NONREIMBURSABLE COST CENTERS | 93, 176 | 0 | 93, 17 | | 194.00 |
| | 07951 OTHER NONREIMBURSABLE COST CENTERS | 421 | 0 | 42 | | 194. 01 |
| 200.00 | | 0 | 0 | | 0 | 200.00 |
| 201.00 | | 0 | 0 | 0.001.40 | | 201.00 |
| 202.00 | TOTAL (sum lines 118 through 201) | 2, 081, 629 | I U | 2, 081, 62 | 7 | 202.00 |
| | | | | | | |

| COST A | Financial Systems Fi LLOCATION - STATISTICAL BASIS | AYETTE REGIONAL | HEALTH SYSTEM Provider C | CN: 15-0064 F | Period: | u of Form CMS-2 Worksheet B-1 | |
|--|--|------------------------------|-----------------------------|----------------|---|----------------------------------|-------------------------------|
| | | | | | rom 10/01/2017 o 09/30/2018 | Date/Time Pre 2/28/2019 1:0 | pared: 2 pm |
| | | | | | | 272072017 1.0 | |
| | Cost Center Description | RELATED COSTS BLDG & FIXT | EMPLOYEE | Reconciliatior | ADMI NI STRATI VE | OPERATION OF | |
| | | (SQUARE FEET) | BENEFITS | | & GENERAL | PLANT | |
| | | | DEPARTMENT (GROSS | | (ACCUM. COST) | (SQUARE FEET) | |
| | | | SALARI ES) | | | | |
| | | 1.00 | 4.00 | 5A | 5.00 | 7.00 | |
| | GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT | 400, 430 | | | | | 1.00 |
| | 00400 EMPLOYEE BENEFITS DEPARTMENT | 1, 591 | 20, 739, 779 | | | | 4.00 |
| 5.00 | 00500 ADMI NI STRATI VE & GENERAL | 25, 764 | 2, 081, 610 | | 34, 478, 186 | | 5.00 |
| | 00700 OPERATION OF PLANT | 171, 365 | 367, 183 | C | _,, | 210, 803 | |
| | 00701 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE | 0 491 | 0 | | 970, 645 112, 710 | 0 491 | 7.01 8.00 |
| | 00900 HOUSEKEEPING | 2, 021 | 592, 002 | | 840, 698 | 2, 021 | 9.00 |
| | 01000 DI ETARY | 2, 823 | 261, 738 | c | 0.2/0/0 | 2, 823 | |
| | 01100 CAFETERIA | 4, 097 | 313, 288 | C | 387, 199 | 4, 097 | 1 |
| | 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY | 0 2,687 | 793, 762 85, 869 | | , | 0 2, 687 | 13.00 14.00 |
| | 01500 PHARMACY | 2,600 | 359, 467 | | | 2,600 | 1 |
| 16.00 | 01600 MEDI CAL RECORDS & LI BRARY | 3, 897 | 792, 941 | C | | 3, 897 | 16.00 |
| | INPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS | 22.040 | 1 500 373 | С | 0 507 404 | 22.0/2 | 30.00 |
| | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT | 22, 860 9, 291 | 1, 590, 263 808, 862 | | | 22, 860 9, 291 | 30.00 |
| | 04000 SUBPROVI DER – I PF | 7, 895 | 122, 863 | | | 7, 895 | 1 |
| | 04100 SUBPROVI DER – I RF | 0 | 0 | c c | - | 0 | 41.00 |
| | 04200 SUBPROVI DER | 0 | 0 | C | | 0 | 42.00 |
| 43.00 | 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS | 4,662 | 283, 896 | C | 443, 599 | 4, 662 | 43.00 |
| 50.00 | 05000 OPERATI NG ROOM | 24, 800 | 614, 581 | C | 1, 146, 120 | 24, 800 | 50.00 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 22, 068 | 1, 246, 598 | c | | 22, 068 | |
| | | 7,140 | 711, 386 | | | 7, 140 | |
| | 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY | 3, 586 7, 761 | 421, 698 474, 304 | | | 3, 586 7, 761 | 65.00 66.00 |
| | 06900 ELECTROCARDI OLOGY | 0 | 0 | | | 0 | 69.00 |
| | 06901 CARDI AC REHAB | 2, 982 | 184, 090 | C | 263, 324 | 2, 982 | 69.01 |
| | 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | C | - | 0 | 71.00 |
| | 07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | | 0 | |
| | OUTPATIENT SERVICE COST CENTERS | <u> </u> | | ~ | | | / 0. 00 |
| | 09100 EMERGENCY | 8, 510 | 1, 293, 122 | C | 1, 868, 900 | 8, 510 | 1 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) 04050 CLINIC | 25, 802 | 4, 750, 319 | l c | 4, 105, 603 | 25, 802 | 92.00 93.00 |
| | 04950 BI C | 23, 002 | 4,730,319 | | | 23,002 | 93.00 |
| | 04954 PODI ATRY | 0 | 0 | C | 0 | 0 | 93.05 |
| | OTHER REIMBURSABLE COST CENTERS | | 0 | | | 0 | |
| | 09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY | 0 | 0 | | | | 95.00 101.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | Ū | |
| | 11600 HOSPI CE | 0 | 0 | C | - | | 116.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS | 364, 693 | 18, 149, 842 | -7, 709, 470 | 28, 923, 919 | 165, 973 | 118.00 |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | C | 0 | 0 | 190.00 |
| | 19100 RESEARCH | 0 | 0 | c | | | 191.00 |
| | 19101 FMH DIAGNOSTIC CENTER | 0 | 82, 749 | C | | | 191.01 |
| | 19102 WELLNESS 19200 PHYSI CLANS' PRI VATE OFFI CES | 1, 238 | 84, 111 12, 666 | | 244, 808 33, 129 | | 191. 02 192. 00 |
| | 19201 RFE | 0 | 12,000 | | 3, 655 | | 192.00 |
| | 19202 MARKETI NG | 1, 305 | 83, 461 | c | 304, 648 | | 192. 02 |
| | 19203 FOUNDATION | 1, 410 | 0 | 0 | 7, 330 | | 192.03 |
| | 19206 HEART CENTER 19207 WVCP | 943 21, 084 | 0 2, 252, 766 | | | | 192.06 192.07 |
| | 19208 OCCUPATIONAL MED | 0 | 2,202,700 | | 667 | | 192.07 |
| | 19210 HOSPI TALI ST | 0 | 5, 500 | C | 599, 900 | | 192. 10 |
| | 07950 OTHER NONREIMBURSABLE COST CENTERS | 9, 757 | 0 | | 50, 707 | | 194.00 |
| 194.00 | OTOEL OTHED NONDEL MOUDSARLE COST CENTERS | i () | 68, 684 | | 100, 844 | 0 | 194. 01 200. 00 |
| 194.00 194.01 | 07951 OTHER NONREI MBURSABLE COST CENTERS | 0 | | | | | |
| 194.00 | Cross Foot Adjustments Negative Cost Centers | Ŭ | | | | | 201.00 |
| 194.00 194.01 200.00 | Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, | 2, 081, 629 | 3, 565, 025 | | 7, 709, 470 | 2, 530, 889 | 1 |
| 194.00 194.01 200.00 201.00 202.00 | Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) | | | | | | 202.00 |
| 194.00 194.01 200.00 201.00 202.00 203.00 | Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) | 2, 081, 629 5. 198484 | 0. 171893 | | 0. 223604 | 12.005944 | 202. 00 203. 00 |
| 194.00 194.01 200.00 201.00 202.00 | Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) | | | | | | 202. 00 203. 00 204. 00 |

| AYETTE REGIONAL | HEALTH SYSTEM | 1 | In Lie | eu of Form CMS- | 2552-10 |
|------------------------------|---|--|---|--|---|
| | Provider CCN: 15-0064 | | | Worksheet B-1 | |
| | | | | | |
| CAPI TAL | | | | | |
| BLDG & FIXT (SQUARE FEET) | EMPLOYEE BENEFI TS | Reconciliatio | n ADMI NI STRATI VE & GENERAL | OPERATION OF PLANT | |
| | DEPARTMENT (GROSS | | (ACCUM. COST) | (SQUARE FEET) | |
| 1.00 | | | | 7.00 | |
| | 4.00 | 5A | 5.00 | 7.00 | 201 00 |
| | | | | | 206.00 |
| | | | | | 207.00 |
| | CAPI TAL RELATED COSTS BLDG & FI XT | CAPI TAL <u>RELATED COSTS</u> BLDG & FI XT (SQUARE FEET) EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES) | CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET) BENEFITS DEPARTMENT (GROSS SALARIES) | Provider CCN: 15-0064 Period: From 10/01/2017 To 09/30/2018 CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET) EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) Reconciliation (ADMINISTRATIVE & GENERAL (ACCUM. COST) | Provider CCN: 15-0064Period: From 10/01/2017 To 09/30/2018Worksheet B-1CAPITAL RELATED COSTSEMPLOYEE BENEF ITS DEPARTMENT (GROSS SALARI ES)ReconciliationADMINISTRATIVE & GENERAL (ACCUM. COST)Worksheet B-1Department (SQUARE FEET)EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARI ES)ReconciliationADMINISTRATIVE (SQUARE FEET)OPERATION OF PLANT (SQUARE FEET) |

| JOT ALL | OCATION - STATISTICAL BASIS | | Provider C | F | eriod: rom 10/01/2017 | Worksheet B-1 | |
|-------------------------|---|--|--|--------------------------------|----------------------------|--------------------------------|------------------|
| | | | | T | 09/30/2018 | Date/Time Pre 2/28/2019 1:0 | |
| | Cost Center Description | OPERATION OF PLANT (SQUARE FEET) | LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) | HOUSEKEEPI NG (SQUARE FEET) | DI ETARY (MEALS SERVED) | CAFETERIA (MAN HOURS) | |
| | | 7.01 | 8.00 | 9.00 | 10.00 | 11.00 | |
| | ENERAL SERVICE COST CENTERS | | | | | | |
| 00 00 00 00 00 00 | D100 CAP REL COSTS-BLDG & FIXT D400 EMPLOYEE BENEFITS DEPARTMENT D500 ADMINISTRATIVE & GENERAL D700 OPERATION OF PLANT | | | | | | 1 4 5 7 |
| 0 00 | D701 OPERATION OF PLANT D800 LAUNDRY & LINEN SERVICE | 145, 045 491 | 63, 248 | | | | 8 |
| | 0900 HOUSEKEEPI NG 1000 DI ETARY | 2, 021 2, 823 | 0 6, 817 | 203, 965 2, 823 | | | 10 |
| | 1100 CAFETERI A | 4, 097 | 0, 017 | 4, 097 | | 516, 983 | |
| | 1300 NURSI NG ADMI NI STRATI ON | 0 | 0 | 0 | | 0 | |
| | 1400 CENTRAL SERVICES & SUPPLY | 2, 687 | 0 | 2, 687 | | 0 | 14 |
| | 1500 PHARMACY 1600 MEDICAL RECORDS & LIBRARY | 2,600 | 0 | | | 0 | 15 |
| | NPATIENT ROUTINE SERVICE COST CENTERS | 3, 897 | 0 | 3, 897 | 0 | 21, 586 | 16 |
| | 3000 ADULTS & PEDI ATRI CS | 22, 860 | 16, 046 | 22, 860 | 28, 381 | 41, 518 | 30 |
| | 3100 I NTENSI VE CARE UNI T | 9, 291 | 5, 851 | 9, 291 | | 28, 240 | |
| | 4000 SUBPROVI DER – I PF 4100 SUBPROVI DER – I RF | 0 | 0 | 7, 895 0 | | 5, 886 0 | |
| | 4200 SUBPROVI DER | 0 | 0 | | | 0 | |
| 00 04 | 4300 NURSERY | 4, 662 | 0 | 4, 662 | 0 | 7, 560 | |
| | NCILLARY SERVICE COST CENTERS | | | | - | | |
| | 5000 OPERATI NG ROOM 5400 RADI OLOGY-DI AGNOSTI C | 24, 800 22, 068 | 5, 733 8, 498 | 24, 800 22, 068 | | 21, 162 39, 667 | 50 54 |
| | 5000 LABORATORY | 7, 140 | 0, 490 | 7, 140 | | 29, 995 | |
| | 5500 RESPI RATORY THERAPY | 3, 586 | 0 | 3, 586 | | 15, 626 | |
| | 6600 PHYSI CAL THERAPY | 7, 761 | 7, 291 | 7, 761 | 0 | 15, 958 | |
| | 6900 ELECTROCARDI OLOGY 6901 CARDI AC REHAB | 0 2, 982 | 0 535 | 0 2, 982 | - | 7, 325 0 | 69 |
| | 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 2,902 | 0355 | 2,902 | | 119, 198 | |
| | 7200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | 0 | | 0 | 72 |
| | 7300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 73 |
| | JTPATIENT SERVICE COST CENTERS 9100 EMERGENCY | 8, 510 | 11, 213 | 8, 510 | 3, 121 | 41, 064 | 9. |
| | 9200 OBSERVATION BEDS (NON-DISTINCT PART) | 0,510 | 11, 213 | 6, 510 | 3, 121 | 41,004 | 92 |
| 00 04 | 4050 CLI NI C | 7, 873 | 40 | 25, 802 | 0 | 0 | |
| | 4950 BIC | 0 | 0 | 0 | | 0 | 93 |
| | 4954 PODIATRY FHER REIMBURSABLE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 93 |
| | 9500 AMBULANCE SERVICES | 0 | 0 | 0 | 0 | 0 | 95 |
| | D100 HOME HEALTH AGENCY | 0 | 0 | 0 | 0 | 0 | 101 |
| | PECIAL PURPOSE COST CENTERS | 0 | 0 | | | 0 | 111/ |
| 3. 00 | 1600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) DNREIMBURSABLE COST CENTERS | 0 140, 149 | 0 62, 024 | 0 163, 461 | | 394, 785 | 116 |
| | 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | | | 190 |
| | 9100 RESEARCH 9101 FMH DIAGNOSTIC CENTER | 0 | 0 | 0 | - | | 191 191 |
| | 9102 WELLNESS | 0 | 0 | 9, 093 | - | 6, 263 | 191 |
| 2.00 19 | 9200 PHYSICIANS' PRIVATE OFFICES | 1, 238 | 1, 019 | 1, 238 | 34, 218 | 4, 604 | 192 |
| | | 0 | 0 | 0 | - | | 192 |
| | 9202 MARKETI NG 9203 FOUNDATI ON | 1, 305 1, 410 | 0 | 1, 305 1, 410 | | | 192 192 |
| 1 | 9206 HEART CENTER | 943 | 0 | 943 | | | 192 |
| 2. 07 19 | 9207 WVCP | 0 | 205 | 20, 745 | 0 | 111, 243 | 192 |
| | 9208 OCCUPATIONAL MED | 0 | 0 | 0 | 0 | | 192 |
| | 9210 HOSPI TALI ST 7950 OTHER NONREI MBURSABLE COST CENTERS | 0 | 0 | 5, 770 | 0 | | 192 194 |
| | 7951 OTHER NONREI MBURSABLE COST CENTERS | 0 | 0 | 0 | 0 | | 194 |
| 0. 00 | Cross Foot Adjustments | | | | | | 200 |
| 1.00 | Negative Cost Centers | 1 107 /05 | 1/7 007 | 1 040 404 | 714 714 | E77 007 | 201 |
| 2.00 | Cost to be allocated (per Wkst. B, Part I) | 1, 187, 685 | 147, 827 | 1, 069, 494 | 714, 714 | 577, 997 | 202 |
| 3.00 4.00 | Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, | 8. 188390 3, 794 | 2. 337260 5, 100 | | | 1. 118019 40, 974 | |
| 5. 00 | Part II) Unit cost multiplier (Wkst. B, Part | 0. 026157 | 0. 080635 | 0. 111299 | 0. 406546 | 0. 079256 | 20! |
| 5. 00 |) NAHE adjustment amount to be allocated | | | | | | 206 |
| 7 00 | (per Wkst. B-2) | | | | | | 00- |
| 7.00 | NAHE unit cost multiplier (Wkst. D, | | | 1 | | | 207 |

| ST ALI | Financial Systems F LOCATION - STATISTICAL BASIS | AYETTE REGIONAL | Provider CC | | Peri od: | u of Form CMS-255 Worksheet B-1 |
|--------|---|-------------------|--------------|-------------|----------------------------------|------------------------------------|
| | | | | | From 10/01/2017 To 09/30/2018 | |
| | Cost Center Description | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | 2/28/2019 1:02 p |
| | | ADMI NI STRATI ON | SERVICES & | (100%) | RECORDS & | |
| | | (| SUPPLY | | LI BRARY | |
| | | (FTE'S) | (100%) | | (GROSS | |
| | | 13.00 | 14.00 | 15.00 | CHARGES) 16.00 | |
| G | SENERAL SERVICE COST CENTERS | 13.00 | 14.00 | 15.00 | 10.00 | |
| | DO100 CAP REL COSTS-BLDG & FIXT | | | | | |
| 0 0 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | |
| | 00500 ADMI NI STRATI VE & GENERAL | | | | | |
| | 00700 OPERATION OF PLANT | | | | | |
| | 00701 OPERATION OF PLANT | | | | | |
| | 00800 LAUNDRY & LINEN SERVICE | | | | | 8 |
| | 00900 HOUSEKEEPI NG 01000 DI ETARY | | | | | 10 |
| | 01100 CAFETERI A | | | | | 1 |
| | 01300 NURSI NG ADMI NI STRATI ON | 115 | | | | 1: |
| | 01400 CENTRAL SERVICES & SUPPLY | 0 | 100 | | | 14 |
| 00 0 | 01500 PHARMACY | 0 | 0 | 10 | 00 | 1! |
| | 01600 MEDICAL RECORDS & LIBRARY | 0 | 0 | | 0 88, 828, 050 | 10 |
| | NPATIENT ROUTINE SERVICE COST CENTERS | 1 | | | | |
| | 03000 ADULTS & PEDIATRICS | 5 | 0 | | 0 5, 997, 607 | 30 |
| | 03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF | 0 | 0 | | 0 1, 131, 255 | 3 |
| |)4000 SUBPROVIDER – TPF)4100 SUBPROVIDER – TRF | | 0 | | 0 312, 778 0 0 | 40 |
| | 04200 SUBPROVIDER | 0 | 0 | | 0 0 | 4 |
| | 04300 NURSERY | 0 | 0 | | 0 385, 214 | 43 |
| - | NCI LLARY SERVICE COST CENTERS | · · · · · · | | | | |
| 00 0 | D5000 OPERATING ROOM | 10 | 0 | | 0 4, 538, 053 | 50 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 19 | 0 | | 0 24, 972, 751 | 54 |
| | 06000 LABORATORY | 14 | 0 | | 0 15, 647, 461 | 60 |
| | | 8 | 0 | | 0 3, 413, 056 | 6 |
| | 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY | 8 | 0 | | 0 1, 515, 128 | 60 |
| | 06901 CARDI AC REHAB | 4 | 0 | | 0 434, 443 | 69 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 100 | | 0 1, 523, 409 | 7 |
| | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | | 0 637, 133 | 7: |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 10 | | 7: |
| | DUTPATIENT SERVICE COST CENTERS | 1 | | | | |
| | 09100 EMERGENCY | 20 | 0 | | 0 14, 140, 843 | 9 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 27 | | | 0 F 001 F0/ | 92 |
| | 04050 CLI NI C 04950 BI C | 27 | 0 | | 0 5, 291, 506 0 2, 474 | 93 |
| | 04950 BTC 04954 PODI ATRY | 0 | 0 | | 0 2,474 | 93 |
| - | THER REIMBURSABLE COST CENTERS | | | | 0 0 | |
| | 09500 AMBULANCE SERVICES | 0 | 0 | | 0 0 | 9! |
| . 00 1 | 10100 HOME HEALTH AGENCY | 0 | 0 | | 0 0 | 10 ⁻ |
| | SPECIAL PURPOSE COST CENTERS | | | | | |
| | 11600 HOSPI CE | 0 | 0 | | 0 0 | 110 |
| 3.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 115 | 100 | 10 | 00 88, 828, 050 | 118 |
| | IONREI MBURSABLE COST CENTERS | 0 | 0 | | 0 0 | 190 |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | | 0 0 | 190 |
| | 19101 FMH DIAGNOSTIC CENTER | 0 | 0 | | 0 0 | 19 |
| | 19102 WELLNESS | 0 | 0 | | 0 0 | 19 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | 0 | | 0 0 | 192 |
| | 19201 RFE | 0 | 0 | | 0 0 | 192 |
| | 19202 MARKETI NG | 0 | 0 | | 0 0 | 19: |
| | 19203 FOUNDATION | 0 | 0 | | 0 0 | 192 |
| | 9206 HEART CENTER 19207 WVCP | 0 | 0 | | 0 0 | 19: 19: |
| | 19207 WVCP 19208 OCCUPATI ONAL MED | | 0 | | | 192 |
| | 19208 OCCOPATIONAL MED | | 0 | | 0 0 | 192 |
| | 07950 OTHER NONREI MBURSABLE COST CENTERS | 0 | 0 | | 0 0 | 194 |
| | 07951 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | | 0 0 | 194 |
| . 00 | Cross Foot Adjustments | | | | | 200 |
| . 00 | Negative Cost Centers | | | | | 201 |
| 2.00 | Cost to be allocated (per Wkst. B, | 1, 215, 977 | 803, 739 | 3, 250, 22 | 1, 560, 598 | 202 |
| | Part I) | 10 572 7400 10 | 0 007 000000 | 22 502 2462 | 0 047510 | |
| 3.00 | Unit cost multiplier (Wkst. B, Part I) | 1 1 | 8,037.390000 | | | 203 |
| 1.00 | Cost to be allocated (per Wkst. B, Part II) | 4, 202 | 28, 180 | 35, 27 | 44,034 | 204 |
| 5. 00 | Unit cost multiplier (Wkst. B, Part | 36. 539130 | 281.800000 | 352.77000 | 0. 000496 | 20! |
| | | 00.007100 | 231.000000 | 332.77000 | 0.000470 | |
| 5.00 | NAHE adjustment amount to be allocated | | | | | 200 |
| | (per Wkst. B-2) | 1 | | | 1 | |

| Health Financial Systems F | AYETTE REGIONAL | HEALTH SYSTEM | | In Lie | u of Form CMS- | 2552-10 |
|--|-------------------|-----------------------|----------|----------------------------------|--------------------------------|----------------|
| COST ALLOCATION - STATISTICAL BASIS | | Provider CCN: 15-0064 | | Period: | Worksheet B-1 | |
| | | | | From 10/01/2017 To 09/30/2018 | Date/Time Pre 2/28/2019 1:0 | pared: 2 pm |
| Cost Center Description | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | | |
| | ADMI NI STRATI ON | SERVICES & | (100%) | RECORDS & | | |
| | | SUPPLY | | LI BRARY | | |
| | (FTE'S) | (100%) | | (GROSS | | |
| | | | | CHARGES) | | |
| | 13.00 | 14.00 | 15.00 | 16.00 | | |
| 207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV) | | | | | | 207.00 |

| Heal th | Fi nan | ci a | ıl Syst | ems | | | |
|---------|--------|------|---------|-----|-------|----|---|
| COMPLIE | | OF | DATIO | OF | COSTS | ΤO | 0 |

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

| Cost Center Description | Total Cost | Title | VV/LLL | | 2/28/2019 1:0 | |
|--|---------------------------------------|-----------------------|-------------|------------------------|---------------|-----------|
| Cost Center Description | Total Cost | | AVI I I | Hospi tal | PPS | |
| Cost Center Description | Total Cost | | | Costs | | |
| | (from Wkst. B, Part I, col. 26) | Therapy Limit Adj. | Total Costs | RCE Di sal I owance | Total Costs | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5,00 | <u> </u> |
| INPATIENT ROUTINE SERVICE COST CENTERS | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 0. 00 03000 ADULTS & PEDIATRICS | 4, 205, 180 | 1 | 4, 205, 18 | | 4, 205, 180 | 30 00 |
| 1. 00 03100 INTENSIVE CARE UNIT | 1, 834, 977 | | 1, 834, 97 | | 1, 834, 977 | |
| 0. 00 04000 SUBPROVIDER - IPF | 636, 521 | | 636, 52 | | 636, 521 | |
| 1. 00 04100 SUBPROVIDER - IRF | 030, 321 | | 030, 32 | | 030, 321 | |
| 2. 00 04200 SUBPROVI DER | 0 | | | | 0 | |
| 3. 00 04300 NURSERY | 676, 601 | | 676, 60 | 1 0 | 676, 601 | |
| ANCI LLARY SERVI CE COST CENTERS | 070,001 | 1 | 070,00 | <u> </u> | 070,001 | |
| 0. 00 05000 OPERATING ROOM | 2, 255, 781 | | 2, 255, 78 | 1 0 | 2, 255, 781 | 50 00 |
| 4. 00 05400 RADI OLOGY-DI AGNOSTI C | 5, 066, 163 | | 5, 066, 16 | | 5, 066, 163 | |
| 0. 00 06000 LABORATORY | 3, 173, 720 | | 3, 173, 72 | | 3, 173, 720 | |
| 5. 00 06500 RESPI RATORY THERAPY | 976, 002 | | 976, 00 | | 976, 002 | |
| 6. 00 06600 PHYSI CAL THERAPY | 1, 128, 747 | | 1, 128, 74 | | 1, 128, 747 | |
| 9. 00 06900 ELECTROCARDI OLOGY | 50, 484 | | 50, 48 | | 50, 484 | |
| 9. 01 06901 CARDI AC REHAB | 406, 943 | | 406, 94 | | 406, 943 | |
| 1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 963, 771 | | 963, 77 | | 963, 771 | |
| 2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS | 368, 399 | | 368, 39 | | 368, 399 | |
| 3. 00 07300 DRUGS CHARGED TO PATIENTS | 3, 406, 323 | | 3, 406, 32 | | 3, 406, 323 | |
| OUTPATIENT SERVICE COST CENTERS | 0,100,020 | | 0,100,02 | <u> </u> | 07 1007 020 | 1 1 01 00 |
| 1.00 09100 EMERGENCY | 3, 065, 774 | | 3, 065, 77 | 4 0 | 3, 065, 774 | 91.00 |
| 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 590, 094 | | 590, 09 | | 590, 094 | |
| 3. 00 04050 CLINIC | 5, 911, 733 | | 5, 911, 73 | | 5, 930, 935 | |
| 3. 01 04950 BIC | 43 | | 4 | | 43 | 1 |
| 3. 05 04954 PODI ATRY | 0 | | | 0 0 | 0 | |
| OTHER REIMBURSABLE COST CENTERS | | 1 | | -1 -1 | | |
| 5. 00 09500 AMBULANCE SERVICES | 0 | | | 0 0 | 0 | 95.00 |
| 01.00 10100 HOME HEALTH AGENCY | 0 | | | 0 | 0 | 101.00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | 1 |
| 16. 00 11600 H0SPI CE | 0 | | | 0 | 0 | 116.00 |
| 00.00 Subtotal (see instructions) | 34, 717, 256 | 0 | 34, 717, 25 | 6 19, 202 | | |
| 01.00 Less Observation Beds | 590, 094 | | 590, 09 | | 590, 094 | |
| 02.00 Total (see instructions) | 34, 127, 162 | | | | | |

| | | AYETTE REGIONAL | | | | u of Form CMS- | 2552-10 |
|----------------|--|-----------------|------------------------|--------------------------|---|--------------------------------|------------------|
| COMPUT | ATION OF RATIO OF COSTS TO CHARGES | | Provider C | | Period: From 10/01/2017 To 09/30/2018 | 2/28/2019 1:0 | epared:)2 pm |
| | | | | e XVIII | Hospi tal | PPS | |
| | Cost Center Description | I npati ent | Charges Outpati ent | Total (col. + col. 7) | 6 Cost or Other Ratio | TEFRA I npati ent Rati o | |
| | | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 5, 328, 585 | | 5, 328, 58 | 15 | | 30.00 |
| 31.00 | 03100 I NTENSI VE CARE UNI T | 1, 131, 255 | | 1, 131, 25 | 5 | | 31.00 |
| 40.00 | 04000 SUBPROVI DER – I PF | 312, 778 | | 312, 77 | 8 | | 40.00 |
| 41.00 | 04100 SUBPROVI DER – I RF | 0 | | | 0 | | 41.00 |
| 42.00 | 04200 SUBPROVI DER | 0 | | | 0 | | 42.00 |
| 43.00 | 04300 NURSERY | 385, 214 | | 385, 21 | 4 | | 43.00 |
| | ANCI LLARY SERVI CE COST CENTERS | I | | 1 | | | |
| 50.00 | 05000 OPERATING ROOM | 781, 070 | 3, 756, 983 | | | 0.00000 | |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 1, 713, 603 | 23, 259, 148 | | | 0.00000 | |
| 60.00 | 06000 LABORATORY | 1, 980, 980 | 13, 666, 481 | | | 0.00000 | |
| 65.00 | 06500 RESPI RATORY THERAPY | 867,000 | 2, 546, 056 | | | 0.00000 | |
| 66.00 | 06600 PHYSI CAL THERAPY | 89, 496 | 1, 425, 632 | 1, 515, 12 | | 0. 000000 | |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | 404.44 | 0 0.00000 | 0. 000000 | |
| 69.01 | 06901 CARDI AC REHAB | 572,202 | 434, 443 | | | 0. 000000 | |
| 71.00 72.00 | 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS | 572, 202 | 951, 207 | | | 0. 000000 0. 000000 | |
| | 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS | 15,732 | 621, 401 | | | | |
| 73.00 | OUTPATIENT SERVICE COST CENTERS | 1, 861, 437 | 7, 023, 502 | 8, 884, 93 | 0. 383382 | 0. 000000 | / /3.00 |
| 91.00 | 09100 EMERGENCY | 731, 118 | 13, 409, 725 | 14, 140, 84 | 3 0. 216803 | 0, 000000 | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | /31, 110 | 669, 022 | | | 0.000000 | |
| | 04050 CLINIC | 6, 346 | 5, 285, 160 | | | 0.000000 | |
| | 04950 BI C | 0, 340 | 2, 474 | | | 0.000000 | |
| | 04954 PODI ATRY | 0 | 2, 1, 1 | | 0 0.000000 | | |
| /01/00 | OTHER REIMBURSABLE COST CENTERS | | | 1 | 0 0100000 | 0100000 | |
| 95.00 | 09500 AMBULANCE SERVICES | 0 | C | | 0 0.000000 | 0, 000000 | 95.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | C | | 0 | | 101.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 116.00 | 11600 HOSPI CE | 0 | C |) | 0 | | 116.00 |
| 200.00 | Subtotal (see instructions) | 15, 776, 816 | 73, 051, 234 | 88, 828, 05 | i0 | | 200. 00 |
| 201.00 | Less Observation Beds | | | | | | 201.00 |
| 202.00 | Total (see instructions) | 15, 776, 816 | 73,051,234 | 88, 828, 05 | io] | | 202.00 |

In Lieu of Form CMS-2552-10

| | ATION OF RATIO OF COSTS TO CHARGES | | Provider CCN: 15-0064 | Peri od: From 10/01/2017 To 09/30/2018 | 2/28/2019 1:0 | epared: |
|--------|--|---------------------------------|-----------------------|--|---------------|----------|
| | | - | Title XVIII | Hospi tal | PPS | |
| | Cost Center Description | PPS Inpatient Ratio 11.00 | | | | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | 11.00 | | | | |
| 30 00 | 03000 ADULTS & PEDIATRICS | | | | | 30.00 |
| | 03100 I NTENSI VE CARE UNI T | | | | | 31.00 |
| | 04000 SUBPROVIDER - IPF | | | | | 40.00 |
| | 04100 SUBPROVIDER - IRF | | | | | 41.00 |
| | 04200 SUBPROVI DER | | | | | 42.00 |
| | 04300 NURSERY | | | | | 43.00 |
| | ANCI LLARY SERVICE COST CENTERS | | | | | |
| 50.00 | 05000 OPERATI NG ROOM | 0. 497081 | | | | 50.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0. 202868 | | | | 54.00 |
| 60.00 | 06000 LABORATORY | 0. 202827 | | | | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0. 285961 | | | | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0. 744985 | | | | 66.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0. 000000 | | | | 69.00 |
| 69.01 | 06901 CARDI AC REHAB | 0. 936701 | | | | 69.01 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 632641 | | | | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0. 578214 | | | | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0. 383382 | | | | 73.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | |
| | 09100 EMERGENCY | 0. 216803 | | | | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 882025 | | | | 92.00 |
| | 04050 CLI NI C | 1. 120841 | | | | 93.00 |
| | 04950 BI C | 0. 017381 | | | | 93.01 |
| 93.05 | 04954 PODI ATRY | 0. 000000 | | | | 93.05 |
| | OTHER REIMBURSABLE COST CENTERS | 1 | | | | |
| | 09500 AMBULANCE SERVI CES | 0. 000000 | | | | 95.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | | | | | 101.00 |
| 444 00 | SPECIAL PURPOSE COST CENTERS | 1 | | | | 111 (00 |
| | 11600 HOSPI CE | | | | | 116.00 |
| 200.00 | | | | | | 200.00 |
| 201.00 | | | | | | 201.00 |
| 202.00 | Total (see instructions) | | | | | 202.00 |

| Heal th | Fi nar | ici a | ıl Syst | ems | | | |
|---------|--------|-------|---------|-----|-------|----|---|
| COMPLIE | | OF | DATIO | OF | COSTS | ΤO | 0 |

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

| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider C | | Period: From 10/01/2017 To 09/30/2018 | | epared: |
|--|----------------|---------------|-------------|---|-------------|---------|
| | | Titl | e XIX | Hospi tal | Cost | |
| | | | | Costs | | |
| Cost Center Description | Total Cost | Therapy Limit | Total Costs | RCE | Total Costs | |
| | (from Wkst. B, | Adj. | | Di sal I owance | | |
| | Part I, col. | | | | | |
| | 26) | | | | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | 1 | | 1 | - | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 4, 205, 180 | | 4, 205, 18 | | 4, 205, 180 | |
| 31.00 03100 INTENSIVE CARE UNIT | 1, 834, 977 | | 1, 834, 97 | 7 0 | 1, 834, 977 | 31.00 |
| 40. 00 04000 SUBPROVIDER - IPF | 636, 521 | | 636, 52 | 1 0 | 636, 521 | |
| 41. 00 04100 SUBPROVIDER - IRF | 0 | | | 0 0 | 0 | 41.00 |
| 42. 00 04200 SUBPROVI DER | 0 | | | 0 0 | 0 | 42.00 |
| 43. 00 04300 NURSERY | 676, 601 | | 676, 60 | 1 0 | 676, 601 | 43.00 |
| ANCI LLARY SERVI CE COST CENTERS | | | _ | | | |
| 50.00 OPERATING ROOM | 2, 255, 781 | | 2, 255, 78 | 1 0 | 2, 255, 781 | 50.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 5, 066, 163 | | 5, 066, 16 | 3 0 | 5, 066, 163 | 54.00 |
| 60. 00 06000 LABORATORY | 3, 173, 720 | | 3, 173, 72 | 0 0 | 3, 173, 720 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 976, 002 | 0 | 976, 00 | 2 0 | 976, 002 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 1, 128, 747 | 0 | 1, 128, 74 | 7 0 | 1, 128, 747 | 66.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 50, 484 | | 50, 48 | 4 0 | 50, 484 | 69.00 |
| 69. 01 06901 CARDI AC REHAB | 406, 943 | | 406, 94 | 3 0 | 406, 943 | 69.01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 963, 771 | | 963, 77 | 1 0 | 963, 771 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 368, 399 | | 368, 39 | 9 0 | 368, 399 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 3, 406, 323 | | 3, 406, 32 | 3 0 | 3, 406, 323 | 73.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 91.00 09100 EMERGENCY | 3, 065, 774 | | 3, 065, 77 | 4 0 | 3, 065, 774 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 590, 094 | | 590, 09 | 4 | 590, 094 | 92.00 |
| 93. 00 04050 CLINIC | 5, 911, 733 | | 5, 911, 73 | 3 19, 202 | 5, 930, 935 | 93.00 |
| 93. 01 04950 BIC | 43 | | 4 | | 43 | 93.01 |
| 93. 05 04954 PODI ATRY | 0 | | | 0 0 | 0 | 93.05 |
| OTHER REIMBURSABLE COST CENTERS | | | • | | | 1 |
| 95.00 09500 AMBULANCE SERVICES | 0 | | | 0 0 | 0 | 95.00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | | | 0 | | 101.00 |
| SPECIAL PURPOSE COST CENTERS | | I | 1 | | | |
| 116. 00 11600 HOSPI CE | 0 | | | 0 | 0 | 116.00 |
| 200.00 Subtotal (see instructions) | 34, 717, 256 | 0 | 34, 717, 25 | 6 19, 202 | | |
| 201.00 Less Observation Beds | 590, 094 | | 590, 09 | | 590, 094 | |
| 202.00 Total (see instructions) | 34, 127, 162 | | | | | |
| (| | | ,, .o | , 202 | , , , , | |

| | 5 | AYETTE REGIONAL | | | | u of Form CMS- | 2552-10 |
|--------|---|-------------------------|-----------------------------|-------------|---|---|----------------|
| COMPUT | ATION OF RATIO OF COSTS TO CHARGES | | Provider C | | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Pre 2/28/2019 1:0 | pared: 2 pm |
| | | | | e XIX | Hospi tal | Cost | |
| | Cost Center Description | Inpati ent | Charges Outpati ent | + col. 7) | 6 Cost or Other Ratio | TEFRA I npati ent Rati o | |
| | | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| | 03000 ADULTS & PEDIATRICS | 5, 328, 585 | | 5, 328, 58 | | | 30.00 |
| | 03100 I NTENSI VE CARE UNI T | 1, 131, 255 | | 1, 131, 25 | | | 31.00 |
| | 04000 SUBPROVI DER – I PF | 312, 778 | | 312, 77 | 8 | | 40.00 |
| | 04100 SUBPROVI DER – I RF | 0 | | | 0 | | 41.00 |
| | 04200 SUBPROVI DER | 0 | | | 0 | | 42.00 |
| 43.00 | 04300 NURSERY | 385, 214 | | 385, 21 | 4 | | 43.00 |
| F0 00 | ANCI LLARY SERVICE COST CENTERS | 704 070 | 0.75(.000 | 4 500 05 | 0 0 107001 | 0,000000 | 50.00 |
| | 05000 OPERATI NG ROOM | 781,070 | 3, 756, 983 | | | 0.00000 | |
| | 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY | 1, 713, 603 | 23, 259, 148 | | | 0.00000 | |
| | 06500 RESPIRATORY THERAPY | 1, 980, 980 867, 000 | 13, 666, 481 2, 546, 056 | | | 0. 000000 0. 000000 | |
| | 06600 PHYSI CAL THERAPY | 89, 496 | 1, 425, 632 | | | 0.000000 | |
| | 06900 ELECTROCARDI OLOGY | 07,470 | 1, 425, 052 | 1, 515, 12 | 0 0. 000000 | 0.000000 | |
| | 06901 CARDI AC REHAB | 0 | 434, 443 | 434, 44 | | 0.000000 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 572, 202 | 951, 207 | | | 0.000000 | 1 |
| | 07200 I MPL. DEV. CHARGED TO PATIENTS | 15, 732 | 621, 401 | | | 0. 000000 | |
| | 07300 DRUGS CHARGED TO PATIENTS | 1, 861, 437 | 7,023,502 | | | 0. 000000 | |
| | OUTPATIENT SERVICE COST CENTERS | | .,, | | | | |
| 91.00 | 09100 EMERGENCY | 731, 118 | 13, 409, 725 | 14, 140, 84 | 3 0. 216803 | 0.00000 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 669, 022 | 669, 02 | 2 0. 882025 | 0.000000 | 92.00 |
| 93.00 | 04050 CLI NI C | 6, 346 | 5, 285, 160 | 5, 291, 50 | 6 1. 117212 | 0. 000000 | 93.00 |
| 93.01 | 04950 BI C | 0 | 2, 474 | | | 0. 000000 | 93.01 |
| 93.05 | 04954 PODI ATRY | 0 | 0 | | 0 0. 000000 | 0.000000 | 93.05 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| | 09500 AMBULANCE SERVI CES | 0 | 0 | | 0 0. 000000 | 0. 000000 | 1 |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 0 | | 0 | | 101.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| | 11600 HOSPI CE | 0 | 0 | | 0 | | 116.00 |
| 200.00 | | 15, 776, 816 | 73, 051, 234 | 88, 828, 05 | 0 | | 200.00 |
| 201.00 | | 45 334 044 | 70 054 004 | | | | 201.00 |
| 202.00 | Total (see instructions) | 15, 776, 816 | 73, 051, 234 | 88, 828, 05 | U | | 202.00 |

| Health Financial Systems | FAYETTE REGIONAL H | HEALTH SYSTEM | In Lieu of Form CMS-2 | | |
|---|--------------------|-----------------------|---|---|--|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider CCN: 15-0064 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/28/2019 1:02 pm | |
| | | Title XIX | Hospi tal | Cost | |
| Cost Center Description | PPS Inpatient | | | | |
| | Ratio | | | | |
| | 11.00 | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | | | | 30.00 | |
| 31.00 03100 INTENSIVE CARE UNIT | | | | 31.00 | |
| 40. 00 04000 SUBPROVIDER - IPF | | | | 40.00 | |
| 41.00 04100 SUBPROVIDER – IRF | | | | 41.00 | |
| 42. 00 04200 SUBPROVI DER | | | | 42.00 | |
| 43.00 04300 NURSERY | | | | 43.00 | |
| ANCI LLARY SERVI CE 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 RESPI RATORY THERAPY | 0. 000000 | | | 65.00 | |
| 66.00 06600 PHYSI CAL THERAPY | 0. 000000 | | | 66.00 | |
| 69.00 06900 ELECTROCARDI OLOGY | 0. 000000 | | | 69.00 | |
| 69. 01 06901 CARDI AC REHAB | 0. 000000 | | | 69.01 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | S 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 | I I | | | | |
| 91.00 09100 EMERGENCY | 0. 000000 | | | 91.00 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | -) 0.000000 | | | 92.00 | |
| 93.00 04050 CLINIC | 0. 000000 | | | 93.00 | |
| 93. 01 04950 BIC | 0. 000000 | | | 93.01 | |
| 93. 05 04954 PODI ATRY | 0. 000000 | | | 93.05 | |
| OTHER REIMBURSABLE COST CENTERS | | | | | |
| 95. 00 09500 AMBULANCE SERVICES | 0. 000000 | | | 95.00 | |
| 101.00 10100 HOME HEALTH AGENCY | | | | 101.00 | |
| SPECIAL PURPOSE COST CENTERS | I | | | | |
| 116. 00 11600 HOSPI CE | | | | 116.00 | |
| 200.00 Subtotal (see instructions) | | | | 200.00 | |
| 201.00 Less Observation Beds | | | | 201.00 | |
| 202.00 Total (see instructions) | | | | 201.00 | |
| | 1 | | | 1202.00 | |

| Health Financial Systems | FAYETTE REGIONAL | HEALTH SYSTEM | | In Lie | u of Form CMS- | <u>2552-10</u> |
|--|------------------|----------------|---------------|---|----------------|----------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP | ITAL COSTS | Provider C | | Period: From 10/01/2017 Fo 09/30/2018 | | pared: 2 pm |
| | | 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 | 249, 311 | 0 | 249, 31 | 1 3, 499 | 71.25 | 30.00 |
| 31.00 INTENSIVE CARE UNIT | 100, 135 | | 100, 13 | 5 204 | 490.86 | 31.00 |
| 40. 00 SUBPROVIDER - IPF | 78, 192 | 0 | 78, 19 | 2 303 | 258.06 | 40.00 |
| 41.00 SUBPROVIDER - IRF | 0 | 0 | | 0 0 | 0.00 | 41.00 |
| 42. 00 SUBPROVI DER | 0 | 0 | | 0 0 | 0.00 | 42.00 |
| 43.00 NURSERY | 47, 396 | | 47, 39 | 5 333 | 142.33 | 43.00 |
| 200.00 Total (lines 30 through 199) | 475, 034 | | 475, 03 | 4 4, 339 | | 200.00 |
| Cost Center Description | I npati ent | Inpati ent | | | | |
| | Program days | Program | | | | |
| | 0 9 | Capital Cost | | | | |
| | | (col. 5 x col. | | | | |
| | | 6) | | | | |
| | 6.00 | 7.00 |] | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 ADULTS & PEDIATRICS | 835 | 59, 494 | | | | 30.00 |
| 31.00 INTENSIVE CARE UNIT | 169 | 82, 955 | | | | 31.00 |
| 40. 00 SUBPROVIDER - IPF | 264 | 68, 128 | | | | 40.00 |
| 41.00 SUBPROVIDER - IRF | 0 | 0 | | | | 41.00 |
| 42.00 SUBPROVI DER | 0 | 0 | | | | 42.00 |
| 43.00 NURSERY | 0 | 0 | | | | 43.00 |
| 200.00 Total (lines 30 through 199) | 1, 268 | 210, 577 | 1 | | | 200.00 |

| | AYETTE REGIONAL | | | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|----------------|---------------|---|--------------------------------|----------------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | L COSTS | Provider C | | Period: From 10/01/2017 To 09/30/2018 | Date/Time Pre 2/28/2019 1:0 | pared: 2 pm |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Capi tal | Total Charges | Ratio of Cos | t Inpatient | Capital Costs | |
| | | (from Wkst. C, | | Program | (column 3 x | |
| | (from Wkst. B, | | (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 | 1 | 1 | 1 | | | |
| 50. 00 05000 OPERATI NG ROOM | 247, 582 | | | | | |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 241, 397 | | | | | 54.00 |
| 60. 00 06000 LABORATORY | 87, 585 | | | | | |
| 65. 00 06500 RESPI RATORY THERAPY | 40, 129 | | | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 80, 108 | 1, 515, 128 | 0. 05287 | 2 62, 298 | 3, 294 | 66.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 727 | 0 | 0.00000 | | 0 | 69.00 |
| 69. 01 06901 CARDI AC REHAB | 29, 990 | 434, 443 | 0. 06903 | 1 0 | 0 | 69.01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 38, 382 | 1, 523, 409 | 0. 02519 | 5 269, 312 | 6, 785 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 1, 457 | 637, 133 | 0. 00228 | 7 3, 345 | 8 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 39, 684 | 8, 884, 939 | 0.00446 | 6 713, 235 | 3, 185 | 73.00 |
| OUTPATIENT SERVICE COST CENTERS | | • | | | | |
| 91.00 09100 EMERGENCY | 102, 699 | | | | 3, 901 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 34, 985 | 669, 022 | 0. 05229 | 3 0 | 0 | 92.00 |
| 93. 00 04050 CLINIC | 268, 798 | 5, 291, 506 | 0. 05079 | 8 339 | 17 | 93.00 |
| 93. 01 04950 BI C | 1 | 2, 474 | 0.00040 | 4 0 | 0 | 93.01 |
| 93. 05 04954 PODI ATRY | 0 | 0 | 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, 213, 524 | 81, 670, 218 | | 4, 380, 261 | 52, 371 | 200. 00 |

| Health Financial Systems F | AYETTE REGIONAL | HEALTH SYSTEM | l | In Lie | eu of Form CMS- | 2552-10 |
|---|---|----------------|--------------|---|--------------------------------|----------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA | ASS THROUGH COST | | | Period: From 10/01/2017 To 09/30/2018 | Date/Time Pre 2/28/2019 1:0 | pared: 2 pm |
| | | | XVIII | Hospi tal | PPS | |
| Cost Center Description | | Nursing School | | h Allied Health | All Other | |
| | Post-Stepdown | | Post-Stepdow | n Cost | Medi cal | |
| | Adjustments | | Adj ustments | | Education Cost | |
| | 1A | 1.00 | 2A | 2.00 | 3.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 0 | C |) | 0 0 | 0 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 0 | C |) | 0 0 | 0 | 31.00 |
| 40. 00 04000 SUBPROVIDER - IPF | 0 | C | | 0 0 | 0 | 40.00 |
| 41. 00 04100 SUBPROVIDER - IRF | 0 | C | | 0 0 | 0 | 41.00 |
| 42. 00 04200 SUBPROVI DER | 0 | C | | 0 0 | l o | 42.00 |
| 43. 00 04300 NURSERY | 0 | 0 | | 0 0 | 0 | 43.00 |
| 200.00 Total (lines 30 through 199) | 0 | 0 | | 0 0 | | 200.00 |
| Cost Center Description | Swing-Bed | Total Costs | Total Patien | t Per Diem (col. | Inpati ent | |
| | Adj ustment | (sum of cols. | Days | 5 ÷ col. 6) | Program Days | |
| | Amount (see | 1 through 3, | | | | |
| | | minus col. 4) | | | | |
| | 4.00 | 5.00 | 6.00 | 7.00 | 8.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 0 | C | 3, 49 | 0.00 | 835 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | | C | 20 | | 169 | 31.00 |
| 40. 00 04000 SUBPROVIDER - 1 PF | 0 | 0 | 30 | | | 1 |
| 41. 00 04100 SUBPROVIDER - IRF | 0 | 0 | | 0 0.00 | | |
| 42. 00 04200 SUBPROVI DER | 0 | 0 | | 0 0.00 | | |
| 43. 00 04300 NURSERY | | 0 | 33 | | | 1 |
| 200.00 Total (lines 30 through 199) | | 0 | 4, 33 | | | 200.00 |
| Cost Center Description | I npati ent | | 1 1/00 | | 1,200 | 200100 |
| | 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 I NTENSI VE CARE UNI T | 0 | | | | | 31.00 |
| 40. 00 04000 SUBPROVI DER – I PF | 0 | | | | | 40.00 |
| 41. 00 04100 SUBPROVI DER – I RF | 0 | | | | | 41.00 |
| 42. 00 04200 SUBPROVI DER | 0 | | | | | 42.00 |
| 43. 00 04300 NURSERY | 0 | | | | | 43.00 |
| 200.00 Total (lines 30 through 199) | | | | | | 200.00 |
| | 0 | I | | | | 1-00.00 |

| Health Financial Systems F/ | AYETTE REGIONAL | HEALTH SYSTEM | | In Lie | eu of Form CMS-2 | 2552-10 |
|--|-----------------|--|-------|---|----------------------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS | VICE OTHER PAS | | | Period: From 10/01/2017 To 09/30/2018 | Date/Time Prep 2/28/2019 1:02 | |
| | | | XVIII | Hospi tal | PPS | |
| Cost Center Description | | Nursing School Post-Stepdown Adjustments | | Allied Health Post-Stepdown Adjustments | | |
| | 1.00 | 2A | 2.00 | 3A | 3.00 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 0 | C | | 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 | 1 | 1 | 1 | | | |
| 91. 00 09100 EMERGENCY | 0 | 0 | | 0 0 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | | 0 | 0 | 92.00 |
| 93. 00 04050 CLI NI C | 0 | 0 | | 0 0 | 0 | 93.00 |
| 93. 01 04950 BIC | 0 | 0 | | 0 0 | 0 | 93.01 |
| 93. 05 04954 PODI ATRY | 0 | 0 | | 0 0 | 0 | 93.05 |
| OTHER REIMBURSABLE COST CENTERS | 1 | I | 1 | | | |
| 95. 00 09500 AMBULANCE SERVICES | | | | | | 95.00 |
| 200.00 Total (lines 50 through 199) | 0 | 0 | 1 | 0 0 | 0 | 200.00 |

| Health Financial Systems F | AYETTE REGIONAL | HEALTH SYSTEM | | In Lie | u of Form CMS- | 2552-10 |
|---|------------------|---------------|--------------|----------------------------------|----------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF | RVICE OTHER PASS | S Provider C | | Period: | Worksheet D | |
| THROUGH COSTS | | | | From 10/01/2017 To 09/30/2018 | | narod |
| | | | | 10 09/30/2018 | 2/28/2019 1:0 | 2 pm |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | All Other | Total Cost | Total | | Ratio of Cost | |
| | Medi cal | (sum of cols. | Outpati ent | (from Wkst. C, | | |
| | Education Cost | 1, 2, 3, and | Cost (sum of | Part I, col. | (col. 5 ÷ col. | |
| | | 4) | col s. 2, 3, | 8) | 7) | |
| | | | and 4) | | | |
| | 4.00 | 5.00 | 6.00 | 7.00 | 8.00 | |
| ANCI LLARY SERVI CE COST CENTERS | 1 | | r | | - | |
| 50.00 05000 OPERATING ROOM | 0 | 0 | | 0 4, 538, 053 | | |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | 0 24, 972, 751 | 0. 000000 | |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 15, 647, 461 | | |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 3, 413, 056 | | |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 1, 515, 128 | | |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0. 000000 | |
| 69. 01 06901 CARDI AC REHAB | 0 | 0 | | 0 434, 443 | 0.00000 | 69.01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 1, 523, 409 | 0.00000 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | | 0 637, 133 | 0.00000 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 8, 884, 939 | 0.00000 | 73.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 91. 00 09100 EMERGENCY | 0 | 0 | | 0 14, 140, 843 | 0.00000 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | 0 669, 022 | 0.00000 | 92.00 |
| 93. 00 04050 CLINIC | 0 | 0 | | 0 5, 291, 506 | 0.000000 | 93.00 |
| 93. 01 04950 BI C | 0 | 0 | | 0 2,474 | 0.000000 | 93.01 |
| 93. 05 04954 PODI ATRY | 0 | 0 | | 0 0 | 0.00000 | 93.05 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 95. 00 09500 AMBULANCE SERVI CES | | | | | | 95.00 |
| 200.00 Total (lines 50 through 199) | 0 | 0 | | 0 81, 670, 218 | | 200. 00 |

| Health Financial Systems F | AYETTE REGIONAL | HEALTH SYSTEM | | In Lie | eu of Form CMS-2 | 2552-10 |
|--|------------------|---------------|---------------|---|------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS | RVICE OTHER PASS | Provider CO | | Period: From 10/01/2017 To 09/30/2018 | | |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Outpatient | Inpati 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. 8 | ; | Costs (col. 9 | |
| | 7) | | x col. 10) | | x col. 12) | |
| | 9.00 | 10.00 | 11.00 | 12.00 | 13.00 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 0. 000000 | 252, 442 | | 0 1, 804, 092 | 0 | 50.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | 898, 666 | | 7, 591, 020 | 0 | 54.00 |
| 60. 00 06000 LABORATORY | 0. 000000 | 1, 071, 589 | | 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 | 0 | 69.00 |
| 69. 01 06901 CARDI AC REHAB | 0.000000 | 0 | | 265, 182 | 0 | 69.01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0.000000 | 269, 312 | | 487, 888 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0.000000 | 3, 345 | | 218, 081 | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 000000 | 713, 235 | | 2, 952, 752 | 0 | 73.00 |
| OUTPATIENT SERVICE COST CENTERS | · · · · · · | | | | | 1 |
| 91.00 09100 EMERGENCY | 0.000000 | 537, 159 | | 3, 217, 316 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0.000000 | 0 | | 638, 795 | 0 | 92.00 |
| 93. 00 04050 CLINIC | 0. 000000 | 339 | | 0 1, 617, 477 | 0 | 93.00 |
| 93. 01 04950 BIC | 0, 000000 | 0 | | o | 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) | | 4, 380, 261 | | 22, 843, 743 | 0 | 200.00 |

| Health Financial Systems FA | AYETTE REGIONAL | . HEALTH SYSTEM | | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|-----------------|--------------|---|---|---------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST | Provider CO | | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Pre 2/28/2019 1:0 | |
| | | Title | XVIII | Hospi tal | PPS | |
| | | | Charges | | Costs | |
| Cost Center Description | Cost to Charge | PPS Reimbursed | Cost | Cost | PPS Services | |
| | Ratio From | Services (see | Reimbursed | Reimbursed | (see inst.) | |
| | Worksheet C, | inst.) | Servi ces | Services Not | | |
| | Part I, col. 9 | | Subject To | Subject To | | |
| | | | Ded. & Coins | | | |
| | | | (see inst.) | (see inst.) | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 0. 497081 | | | 0 0 | 896, 780 | |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 0. 202868 | | | 0 0 | 1, 539, 975 | |
| 60. 00 06000 LABORATORY | 0. 202827 | | | 0 0 | 569, 894 | |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 285961 | 1, 226, 607 | | 0 0 | 350, 762 | |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 744985 | 14, 779 | | 0 0 | 11, 010 | |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | 0 | | 0 0 | 0 | 69.00 |
| 69. 01 06901 CARDI AC REHAB | 0. 936701 | 265, 182 | | 0 0 | 248, 396 | 69.01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 632641 | 487, 888 | | 0 0 | 308, 658 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0. 578214 | 218, 081 | | 0 0 | 126, 097 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 383382 | 2, 952, 752 | | 0 28, 540 | 1, 132, 032 | 73.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 91. 00 09100 EMERGENCY | 0. 216803 | 3, 217, 316 | | 0 0 | 697, 524 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 882025 | 638, 795 | | 0 0 | 563, 433 | 92.00 |
| 93. 00 04050 CLINIC | 1. 117212 | 1, 617, 477 | | 0 0 | 1, 807, 065 | 93.00 |
| 93. 01 04950 BIC | 0. 017381 | 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 | 0. 000000 | | | 0 | | 95.00 |
| 200.00 Subtotal (see instructions) | | 22, 843, 743 | | 0 28, 540 | 8, 251, 626 | 200.00 |
| 201.00 Less PBP Clinic Lab. Services-Program | | | | 0 0 | | 201.00 |
| Only Charges | | | | | | |
| 202.00 Net Charges (line 200 - line 201) | | 22, 843, 743 | | 0 28, 540 | 8, 251, 626 | 202.00 |

| Heal th | Financial Systems F. | AYETTE REGIONAL | HEALTH SYSTEM | | In Lie | u of Form CMS- | -2552-10 |
|---------|--|-----------------|---------------|-------|--|----------------|----------|
| APPORT | ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST | Provider CO | | Peri od: From 10/01/2017 To 09/30/2018 | 2/28/2019 1:0 | |
| | | | | XVIII | Hospi tal | PPS | |
| | | Cos | | | | | |
| | Cost Center Description | Cost | Cost | | | | |
| | | Rei mbursed | Reimbursed | | | | |
| | | Servi ces | Services Not | | | | |
| | | Subject To | Subject To | | | | |
| | | Ded. & Coi ns. | | | | | |
| | | (see inst.) | (see inst.) | | | | |
| | | 6.00 | 7.00 | | | | |
| | ANCI LLARY SERVICE COST CENTERS | | | | | | |
| | 05000 OPERATING ROOM | 0 | 0 | | | | 50.00 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | | | 54.00 |
| | 06000 LABORATORY | 0 | 0 | | | | 60.00 |
| | 06500 RESPI RATORY THERAPY | 0 | 0 | | | | 65.00 |
| | 06600 PHYSI CAL THERAPY | 0 | 0 | | | | 66.00 |
| | 06900 ELECTROCARDI OLOGY | 0 | 0 | | | | 69.00 |
| | 06901 CARDI AC REHAB | 0 | 0 | | | | 69.01 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | | | 71.00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | | | | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 10, 942 | | | | 73.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| | 09100 EMERGENCY | 0 | 0 | | | | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | | | 92.00 |
| | 04050 CLI NI C | 0 | 0 | | | | 93.00 |
| 93.01 | 04950 BI C | 0 | 0 | | | | 93.01 |
| 93.05 | 04954 PODI ATRY | 0 | 0 | | | | 93.05 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 95.00 | 09500 AMBULANCE SERVICES | 0 | | | | | 95.00 |
| 200.00 | Subtotal (see instructions) | 0 | 10, 942 | | | | 200.00 |
| 201.00 | Less PBP Clinic Lab. Services-Program | 0 | | | | | 201.00 |
| | Only Charges | | | | | | |
| 202.00 | Net Charges (line 200 - line 201) | 0 | 10, 942 | | | | 202.00 |

| Health Financial Systems FA | AYETTE REGIONAL | HEALTH SYSTEM | | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|----------------|--------------|----------------------------------|-----------------|----------------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | L COSTS | Provider C | | Peri od: | Worksheet D | |
| | | Component | CCN: 15-S064 | From 10/01/2017 To 09/30/2018 | | narod |
| | | component | JUN. 15-5004 | 10 09/30/2016 | 2/28/2019 1:0 | pareu. 2 nm |
| | | Title | XVIII | Subprovider - | PPS | |
| | | | | I PF | | |
| Cost Center Description | Capi tal | Total Charges | | | Capital Costs | |
| | | (from Wkst. C, | | Program | (column 3 x | |
| | (from Wkst. B, | | | . Charges | column 4) | |
| | Part II, col. | 8) | 2) | | | |
| | 26) | | | | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCI LLARY SERVICE COST CENTERS | 0.47 500 | 4 500 050 | 0.0545 | -7 40 | 0 | 50.00 |
| 50. 00 05000 OPERATING ROOM | 247, 582 | | | | | |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 241, 397 | | | | 1, 460 | |
| 60. 00 06000 LABORATORY | 87, 585 | | | | | |
| 65. 00 06500 RESPI RATORY THERAPY | 40, 129 | | | | 72 | 65.00 |
| 66.00 06600 PHYSI CAL THERAPY | 80, 108 | 1, 515, 128 | | | | |
| 69. 00 06900 ELECTROCARDI OLOGY | 727 | 0 | 0.0000 | | 0 | 69.00 |
| 69. 01 06901 CARDI AC REHAB | 29, 990 | | | | 0 | 69.01 |
| 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS | 38, 382 | | | | 125 | |
| 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS | 1, 457 | | | | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 39, 684 | 8, 884, 939 | 0.00446 | 6 491, 745 | 2, 196 | 73.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 91.00 09100 EMERGENCY | 102, 699 | | | | 773 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | | | 0 | 92.00 |
| 93. 00 04050 CLINIC | 268, 798 | | | | 0 | |
| 93. 01 04950 BIC | 1 | 2, 474 | | | 0 | 93.01 |
| 93. 05 04954 PODI ATRY | 0 | 0 | 0.0000 | 0 0 | 0 | 93.05 |
| OTHER REI MBURSABLE COST CENTERS | | | | | | |
| 95. 00 09500 AMBULANCE SERVICES | 1 170 500 | | | 1 070 107 | | 95.00 |
| 200.00 Total (lines 50 through 199) | 1, 178, 539 | 81, 670, 218 | l | 1, 073, 407 | 7, 641 | 200.00 |

| Heal th | Financial Systems Fi | AYETTE REGIONAL | HEALTH SYSTEM | 1 | In Lieu of Form CMS-2552-10 | | | |
|---------|---|-----------------|--------------------------|--------------|-----------------------------|--------------------------------|----------------|--|
| APPORT | IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER | VICE OTHER PAS | SS Provider CCN: 15-0064 | | Peri od: | Worksheet D | | |
| THROUG | GH COSTS | | Component | CON. 15 5044 | From 10/01/2017 | | norod. | |
| | | | component | CCN: 15-S064 | To 09/30/2018 | Date/Time Pre 2/28/2019 1:0 | pareu: 2 nm | |
| | | | Title | e XVIII | Subprovider - | PPS | | |
| | | | | | ' I PF | | | |
| | Cost Center Description | | | | Allied Health | Allied Health | | |
| | | | Post-Stepdown | | Post-Stepdown | | | |
| | | Cost | Adjustments | | Adjustments | | | |
| | | 1.00 | 2A | 2.00 | 3A | 3.00 | | |
| | ANCI LLARY SERVI CE COST CENTERS | - | - | 1 | - | | | |
| 50.00 | 05000 OPERATING 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 |) | 0 0 | 0 | 60.00 | |
| 65.00 | 06500 RESPI RATORY THERAPY | 0 | C |) | 0 0 | 0 | 65.00 | |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | C |) | 0 0 | 0 | 66.00 | |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | C |) | 0 0 | 0 | 69.00 | |
| 69. 01 | 06901 CARDI AC REHAB | 0 | C | | 0 0 | 0 | 69.01 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | C | | 0 0 | 0 | 71.00 | |
| | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | C | | 0 0 | 0 | 72.00 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | C |) | 0 0 | 0 | 73.00 | |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 91.00 | 09100 EMERGENCY | 0 | C | | 0 0 | 0 | 91.00 | |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | | 0 | 0 | 92.00 | |
| | 04050 CLINIC | 0 | C | | 0 0 | 0 | 93.00 | |
| 93.01 | 04950 BI C | 0 | C | | 0 0 | 0 | 93.01 | |
| 93.05 | 04954 PODI ATRY | 0 | C |) | 0 0 | 0 | 93.05 | |
| | OTHER REIMBURSABLE COST CENTERS | - | 1 | 1 | _ | | | |
| 95.00 | 09500 AMBULANCE SERVICES | | | | | | 95.00 | |
| 200.00 |) Total (lines 50 through 199) | 0 | C | | 0 0 | 0 | 200.00 | |

| Heal th | Financial Systems F | AYETTE REGIONAL | HEALTH SYSTEM | | In Lieu of Form CMS-2552- | | | |
|---------|---|------------------|---------------|-----------------------|----------------------------------|--------------------------------|--------|--|
| APPORT | IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER | RVICE OTHER PASS | S Provider C | Provider CCN: 15-0064 | | Worksheet D | | |
| THROUG | H COSTS | | Component | | From 10/01/2017 To 09/30/2018 | | norod. | |
| | | | Component (| CCN: 15-S064 | To 09/30/2018 | Date/Time Pre 2/28/2019 1:0 | | |
| | | | Title | XVIII | Subprovider - | PPS | 2 pm | |
| | | | | | I PF | | | |
| | Cost Center Description | All Other | Total Cost | Total | | Ratio of Cost | | |
| | | Medi cal | (sum of cols. | Outpati ent | (from Wkst. C, | | | |
| | | Education Cost | 1, 2, 3, and | Cost (sum of | | (col. 5 ÷ col. | | |
| | | | 4) | col s. 2, 3, | 8) | 7) | | |
| | | | | and 4) | | | | |
| | | 4.00 | 5.00 | 6.00 | 7.00 | 8.00 | | |
| | ANCI LLARY SERVI CE COST CENTERS | | | | | | | |
| 50.00 | 05000 OPERATI NG ROOM | 0 | 0 | | 0 4, 538, 053 | | | |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | 0 24, 972, 751 | 0. 000000 | | |
| 60.00 | 06000 LABORATORY | 0 | 0 | | 0 15, 647, 461 | 0.000000 | 60.00 | |
| 65.00 | 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 3, 413, 056 | 0.00000 | | |
| | 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 1, 515, 128 | 0.00000 | | |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0.00000 | 69.00 | |
| 69.01 | 06901 CARDI AC REHAB | 0 | 0 | | 0 434, 443 | 0.00000 | 69.01 | |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 1, 523, 409 | 0.00000 | 71.00 | |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | | 0 637, 133 | 0.00000 | 72.00 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 8, 884, 939 | 0.00000 | 73.00 | |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 91.00 | 09100 EMERGENCY | 0 | 0 | | 0 14, 140, 843 | 0.00000 | 91.00 | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | 0 669, 022 | 0.00000 | 92.00 | |
| 93.00 | 04050 CLI NI C | 0 | 0 | | 0 5, 291, 506 | 0.00000 | 93.00 | |
| 93.01 | 04950 BI C | 0 | 0 | | 0 2,474 | 0.00000 | 93.01 | |
| 93.05 | 04954 PODI ATRY | 0 | 0 | | 0 0 | 0.00000 | 93.05 | |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 95.00 | 09500 AMBULANCE SERVICES | | | | | | 95.00 | |
| 200.00 | Total (lines 50 through 199) | 0 | 0 | | 0 81, 670, 218 | | 200.00 | |
| | | | | | | | | |

| Health Financial Systems F | HEALTH SYSTEM | | In Lieu of Form CMS-2552-10 | | | |
|---|------------------|-------------|-----------------------------|----------------------------------|---------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE | RVICE OTHER PASS | Provider CO | CN: 15-0064 | Period: Worksheet D | | |
| THROUGH COSTS | | Component (| CCN: 15-S064 | From 10/01/2017 To 09/30/2018 | | narod |
| | | component | JON: 13-3004 | 10 097 307 2010 | 2/28/2019 1:0 | |
| | | Title | XVIII | Subprovider - | PPS | |
| | | | | I PF | | |
| Cost Center Description | Outpati ent | Inpatient | Inpati ent | Outpati ent | Outpati ent | |
| | Ratio of Cost | Program | Program | Program | Program | |
| | to Charges | Charges | Pass-Throug | | Pass-Through | |
| | (col. 6 ÷ col. | | Costs (col. | 8 | Costs (col. 9 | |
| | 7) | 10.00 | x col. 10) 11.00 | 12.00 | x col. 12) 13.00 | |
| ANCI LLARY SERVI CE COST CENTERS | 9.00 | 10.00 | 11.00 | 12.00 | 13.00 | |
| 50. 00 05000 OPERATING ROOM | 0. 000000 | 48 | | 0 0 | 0 | 50.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | 151,001 | | 0 0 | 0 | 54.00 |
| 60. 00 06000 LABORATORY | 0. 000000 | 286, 393 | | | 0 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 000000 | 6, 111 | | | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 000000 | 26, 651 | | | 0 | 66.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | 20, 031 | | | 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 | | 73.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | 1 |
| 91. 00 09100 EMERGENCY | 0.00000 | 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 CLINIC | 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, 073, 407 | | 0 0 | 0 | 200. 00 |

| Health Financial Systems F | AYETTE REGIONAL | HEALTH SYSTEM | | In Lie | u of Form CMS-2 | 2552-10 |
|---|--------------------|----------------|--------------|--|--------------------------------|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | AL COSTS | Provider C | CN: 15-0064 | Period: | Worksheet D | |
| | | Component | CCN: 15-T064 | From 10/01/2017 Part II To 09/30/2018 Date/Time | | narod |
| | | component | CCN. 15-1004 | 10 09/30/2016 | Date/Time Pre 2/28/2019 1:0 | |
| | | Title | × XVIII | Subprovider - | PPS | |
| | | | | I RF | | |
| Cost Center Description | Capi tal | Total Charges | | | Capital Costs | |
| | | (from Wkst. C, | | | (column 3 x | |
| | (from Wkst. B, | | N | I. Charges | column 4) | |
| | Part II, col. | 8) | 2) | | | |
| | 26) | 2.00 | 2.00 | 4.00 | F 00 | |
| ANCI LLARY SERVI CE COST CENTERS | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 50. 00 05000 OPERATING ROOM | 247, 582 | 4, 538, 053 | 0.0545 | 57 0 | 0 | 50.00 |
| | | | | | 0 | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY | 241, 397 | | | | - | 60.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 87, 585 40, 129 | | | | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 80, 108 | | | | 0 | 66.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 727 | | 0.0528 | | 0 | 69.00 |
| 69. 01 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB | 29,990 | - | | | | 69.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 38, 382 | | | | 0 | 71.00 |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS | 1, 457 | | | | 0 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 39, 684 | | | | 0 | 73.00 |
| OUTPATIENT SERVICE COST CENTERS | 57,004 | 0,004,939 | 0.0044 | 00 0 | 0 | /3.00 |
| 91. 00 09100 EMERGENCY | 102, 699 | 14, 140, 843 | 0.0072 | 63 0 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 02,077 | | | | 0 | |
| 93. 00 04050 CLINIC | 268, 798 | | | | 0 | |
| 93. 01 04950 BIC | 1 | 2, 474 | | | 0 | |
| 93. 05 04954 PODI ATRY | 0 | 0 | | | 0 | 93.05 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | 1 |
| 95. 00 09500 AMBULANCE SERVICES | | | | | | 95.00 |
| 200.00 Total (lines 50 through 199) | 1, 178, 539 | 81, 670, 218 | | 0 | 0 | 200.00 |
| | | | | 1 | | |

| Heal th | Financial Systems Fi | AYETTE REGIONAL | HEALTH SYSTEM | I | In Lie | u of Form CMS-2 | 2552-10 |
|---------|---|-----------------|---------------|--------------|----------------------------------|--------------------------|----------------|
| APPORT | IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER | VICE OTHER PAS | S Provider C | | Peri od: | Worksheet D | |
| THROUG | GH COSTS | | Component | CCN: 15-T064 | From 10/01/2017 To 09/30/2018 | Part IV Date/Time Pre | norod. |
| | | | component | CCN. 15-1064 | 10 09/30/2016 | 2/28/2019 1:0 | pareu. 2 pm |
| | | | Title | e XVIII | Subprovider - | PPS | |
| | | | | | ' I RF | | |
| | Cost Center Description | | | | Allied Health | Allied Health | |
| | | | Post-Stepdown | | Post-Stepdown | | |
| | | Cost | Adjustments | | Adjustments | | |
| | | 1.00 | 2A | 2.00 | 3A | 3.00 | |
| | ANCI LLARY SERVI CE COST CENTERS | - | - | 1 | - | | |
| 50.00 | 05000 OPERATING ROOM | 0 | C |) | 0 0 | 0 | 50.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | C | 0 | 0 0 | 0 | 54.00 |
| 60.00 | 06000 LABORATORY | 0 | C | 0 | 0 0 | 0 | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0 | C | 0 | 0 0 | 0 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | C |) | 0 0 | 0 | 66.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | C |) | 0 0 | 0 | 69.00 |
| 69.01 | 06901 CARDI AC REHAB | 0 | C |) | 0 0 | 0 | 69.01 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | C |) | 0 0 | 0 | 71.00 |
| | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | C |) | 0 0 | 0 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | C |) | 0 0 | 0 | 73.00 |
| | OUTPATIENT SERVICE COST CENTERS | - | - | | - | | |
| 91.00 | 09100 EMERGENCY | 0 | |) | 0 0 | 0 | 91.00 |
| | | 0 | | | 0 | 0 | 92.00 |
| | 04050 CLINIC | 0 | C |) | 0 0 | 0 | 93.00 |
| 93.01 | 04950 BI C | 0 | C |) | 0 0 | 0 | 93.01 |
| 93.05 | 04954 PODI ATRY | 0 | C |) | 0 0 | 0 | 93.05 |
| | OTHER REIMBURSABLE COST CENTERS | | | 1 | | | |
| 95.00 | 09500 AMBULANCE SERVICES | _ | _ | | | _ | 95.00 |
| 200.00 |) Total (lines 50 through 199) | 0 | C | | 0 0 | 0 | 200.00 |

| Heal th | Financial Systems F | AYETTE REGIONAL | HEALTH SYSTEM | | In Lie | u of Form CMS- | 2552-10 |
|---------|---|------------------|---------------|--------------|----------------------------------|--------------------------------|---------|
| APPORT | IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE | RVICE OTHER PASS | S Provider C | | Period: | Worksheet D | |
| THROUG | H COSTS | | Component | | From 10/01/2017 To 09/30/2018 | | norod. |
| | | | component | CCN: 15-T064 | To 09/30/2018 | Date/Time Pre 2/28/2019 1:0 | |
| | | | Title | XVIII | Subprovider - | PPS | 2 pm |
| | | | | | I RF | | |
| | Cost Center Description | All Other | Total Cost | Total | | Ratio of Cost | |
| | | Medi cal | (sum of cols. | Outpati ent | (from Wkst. C, | | |
| | | Education Cost | 1, 2, 3, and | Cost (sum of | | (col. 5 ÷ col. | |
| | | | 4) | col s. 2, 3, | 8) | 7) | |
| | | | | and 4) | | | |
| | | 4.00 | 5.00 | 6.00 | 7.00 | 8.00 | |
| | ANCI LLARY SERVI CE COST CENTERS | | | | | | - |
| 50.00 | 05000 OPERATI NG ROOM | 0 | 0 | | 0 4, 538, 053 | | |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | 0 24, 972, 751 | 0. 000000 | |
| 60.00 | 06000 LABORATORY | 0 | 0 | | 0 15, 647, 461 | 0.00000 | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 3, 413, 056 | 0.00000 | |
| | 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 1, 515, 128 | 0.00000 | |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0.00000 | 69.00 |
| 69.01 | 06901 CARDI AC REHAB | 0 | 0 | | 0 434, 443 | 0.000000 | 69.01 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 1, 523, 409 | 0.000000 | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | | 0 637, 133 | 0.000000 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 8, 884, 939 | 0.00000 | 73.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 91.00 | 09100 EMERGENCY | 0 | 0 | | 0 14, 140, 843 | 0.000000 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | 0 669, 022 | 0.000000 | 92.00 |
| 93.00 | 04050 CLI NI C | 0 | 0 | | 0 5, 291, 506 | 0.000000 | 93.00 |
| 93.01 | 04950 BI C | 0 | 0 | | 0 2,474 | 0.000000 | 93.01 |
| 93.05 | 04954 PODI ATRY | 0 | 0 | | 0 0 | 0.000000 | 93.05 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 95.00 | 09500 AMBULANCE SERVI CES | | | | | | 95.00 |
| 200.00 | Total (lines 50 through 199) | 0 | 0 | | 0 81, 670, 218 | | 200.00 |
| | | | | | | | |

| Health Financial Systems F | AYETTE REGIONAL | HEALTH SYSTEM | | In Lieu of Form CMS-2552-10 | | | |
|---|------------------|---------------|--------------|----------------------------------|---------------|----------------|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF | RVICE OTHER PASS | Provider C | CN: 15-0064 | Period: Worksheet | | | |
| THROUGH COSTS | | Component | CCN: 15-T064 | From 10/01/2017 To 09/30/2018 | | narad | |
| | | component | JUN: 15-1004 | 10 09/30/2018 | 2/28/2019 1:0 | pareu. 2 pm | |
| | | Title | XVIII | Subprovider - | PPS | | |
| | | | | I RF | | | |
| Cost Center Description | Outpati ent | Inpati ent | Inpati ent | Outpati ent | Outpati ent | | |
| | Ratio of Cost | Program | Program | Program | Program | | |
| | to Charges | Charges | Pass-Throug | | 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 | | |
| ANCI LLARY SERVICE COST CENTERS | · · · · · · | | | | | | |
| 50.00 05000 OPERATI NG ROOM | 0. 000000 | 0 | | 0 0 | 0 | 50.00 | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | 0 | | 0 0 | 0 | 54.00 | |
| 60. 00 06000 LABORATORY | 0. 000000 | 0 | | 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 | 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 | 0 | 72.00 | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 000000 | 0 | | 0 0 | 0 | 73.00 | |
| OUTPATIENT 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 | 1 | 0 0 | 0 | 92.00 | |
| 93. 00 04050 CLI NI C | 0. 000000 | 0 | 1 | 0 0 | 0 | 93.00 | |
| 93. 01 04950 BI C | 0. 000000 | 0 | 1 | 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) | | 0 | | 0 0 | 0 | 200. 00 | |
| | | | | | | | |

Health Financial System

| FAYETTE | REGI ONAL | ΗE | ALTH | S | YS | ΓEΜ | | | |
|---------|-----------|----|------|---|----|-------|-----|------|--|
| | | | - | | | 0.011 | 4.5 | 00/1 | |

In Lieu of Form CMS-2552-10

| Heal th | Financial Systems FAYETTE REGIONAL HE | EALTH SYSTEM | In Lie | u of Form CMS-2 | 2552-10 |
|------------------|---|---------------------------|----------------------------------|------------------|----------------|
| COMPUT | ATION OF INPATIENT OPERATING COST | Provider CCN: 15-0064 | Peri od: | Worksheet D-1 | |
| | | | From 10/01/2017 To 09/30/2018 | Date/Time Pre | pared: |
| | | | | 2/28/2019 1:0 | |
| | Cost Conton Description | Title XVIII | Hospi tal | PPS | |
| | Cost Center Description | | | 1.00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | 1.00 | |
| | INPATIENT DAYS | | | | |
| 1.00 | Inpatient days (including private room days and swing-bed days | | | 3, 499 | 1.00 |
| 2.00 | Inpatient days (including private room days, excluding swing- | | iveta reem deve | 3, 499 0 | 1 |
| 3.00 | Private room days (excluding swing-bed and observation bed day do not complete this line. | ys). It you have only pr | ivate room days, | 0 | 3.00 |
| 4.00 | Semi-private room days (excluding swing-bed and observation be | ed days) | | 3, 008 | 4.00 |
| 5.00 | Total swing-bed SNF type inpatient days (including private roo | om days) through Decembe | er 31 of the cost | 0 | 5.00 |
| | reporting period | | | | 6 4 4 4 |
| 6.00 | Total swing-bed SNF type inpatient days (including private roo 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 room | n davs) 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 |
| | reporting period (if calendar year, enter 0 on this line) | | | 0.05 | |
| 9.00 | Total inpatient days including private room days applicable to newborn days) | o the Program (excluding | swing-bed and | 835 | 9.00 |
| 10.00 | Swing-bed SNF type inpatient days applicable to title XVIII or | nlv (including private r | oom davs) | 0 | 10.00 |
| | through December 31 of the cost reporting period (see instruc | | | | |
| 11.00 | Swing-bed SNF type inpatient days applicable to title XVIII or | | room days) after | 0 | 11.00 |
| 12.00 | December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI) | | a room dave) | 0 | 12.00 |
| 12.00 | through December 31 of the cost reporting period | | e room uays) | 0 | 12.00 |
| 13.00 | Swing-bed NF type inpatient days applicable to titles V or XIX | X only (including privat | e room days) | 0 | 13.00 |
| | after December 31 of the cost reporting period (if calendar ye | ear, enter O on this lin | ie) | | |
| | Medically necessary private room days applicable to the Progra | am (excluding swing-bed | days) | 0 | 14.00 |
| | 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 c | of 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 | s through December 31 of | the cost | 0.00 | 19.00 |
| 17.00 | reporting period | s through becchiber st of | | 0.00 | 17.00 |
| 20. 00 | Medicaid rate for swing-bed NF services applicable to services | s after December 31 of t | he cost | 0.00 | 20.00 |
| 04 00 | reporting period | 、 、 | | 4 005 400 | 01 00 |
| 21. 00 22. 00 | Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December | | ing period (line | 4, 205, 180 0 | 21.00 22.00 |
| 22.00 | 5 x line 17) | er st of the cost report | ing period (inte | 0 | 22.00 |
| 23.00 | Swing-bed cost applicable to SNF type services after December | 31 of the cost reportin | g period (line 6 | 0 | 23.00 |
| | x line 18) | | | _ | |
| 24.00 | Swing-bed cost applicable to NF type services through December 7×1 (ine 19) | r 31 of the cost reporti | ng period (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 | 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) | | 4, 205, 180 | 27.00 |
| 28.00 | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed | and observation bed ch | ardes) | 0 | 28.00 |
| 29.00 | Private room charges (excluding swing-bed charges) | and observation bed ci | lai ges) | 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 | 32.00 |
| 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 | aus lino 22)(soo instruc | tions) | 0.00 0.00 | |
| 34.00 | Average per diem private room cost differential (line 34 x lin | | .(10115) | 0.00 | 1 |
| 36.00 | Private room cost differential adjustment (line 3 x line 35) | | | 0.00 | 36.00 |
| 37.00 | General inpatient routine service cost net of swing-bed cost a | and private room cost di | fferential (line | 4, 205, 180 | 1 |
| | 27 minus line 36) | | | | - |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | ISTMENTS | | | - |
| 38.00 | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see | | | 1, 201. 82 | 38.00 |
| 39.00 | Program general inpatient routine service cost (line 9 x line | | | 1, 003, 520 | 1 |
| 40.00 | Medically necessary private room cost applicable to the Progra | | | 0 | 1 |
| 41.00 | Total Program general inpatient routine service cost (line 39 | + line 40) | | 1, 003, 520 | 1 11 00 |

| | ATION OF INPATIENT OPERATING COST | | Provider C | 5N. 15 0004 | Period: From 10/01/2017 | Worksheet D-1 | 1 |
|---------------|---|-------------------------|-------------------------|-----------------|----------------------------|--------------------------------|-------------|
| | | | | | To 09/30/2018 | Date/Time Pre 2/28/2019 1:0 | |
| | | | Title | XVIII | Hospi tal | PPS | <u>, pi</u> |
| | Cost Center Description | Total Inpatient Cost | Total Inpatient Days | | | Program Cost (col. 3 x col. | |
| | | 1.00 | 2.00 | col. 2) 3.00 | 4.00 | 4) 5.00 | |
| . 00 | NURSERY (title V & XIX only) | 0 | 0 | | | |) 42. |
| | Intensive Care Type Inpatient Hospital Units | | | | | | |
| . 00 | INTENSIVE CARE UNIT CORONARY CARE UNIT | 1, 834, 977 | 204 | 8, 994. 9 | 99 169 | 1, 520, 153 | |
| . 00 | BURN INTENSIVE CARE UNIT | | | | | | 44 |
| . 00 | SURGI CAL I NTENSI VE CARE UNI T | | | | | | 46 |
| . 00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | 47 |
| | Cost Center Description | | | | | 1.00 | _ |
| . 00 | Program inpatient ancillary service cost (Wks | st D-3 col 3 | Line 200) | | | 1.00 1,297,678 | 3 48 |
| . 00 | Total Program inpatient costs (sum of lines 4 | | | ns) | | 3, 821, 351 | |
| | PASS THROUGH COST ADJUSTMENTS | X | | | | | |
| . 00 | Pass through costs applicable to Program inpa | atient routine | services (from | Wkst. D, sun | n of Parts I and | 142, 449 | 9 50 |
| . 00 | III) Pass through costs applicable to Program inpa | atient ancillar | v services (fr | om Wkst D s | sum of Parts II | 52, 371 | 1 51 |
| | and IV) | | , | | | 52, 671 | |
| 2.00 | Total Program excludable cost (sum of lines 5 | | | | | 194, 820 | |
| 8.00 | Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5 | | lated, non-phy | sician anesth | netist, and | 3, 626, 531 | 53 |
| | TARGET AMOUNT AND LIMIT COMPUTATION |) <) | | | | | |
| . 00 | Program di scharges | | | | | C | 54 |
| . 00 | Target amount per discharge | | | | | 0.00 | |
| . 00 | Target amount (line 54 x line 55) | | | | 1 | 0 | |
| 2.00 3.00 | Difference between adjusted inpatient operati Bonus payment (see instructions) | ng cost and ta | rget amount (I | ine 56 minus | Tine 53) | | |
| 9.00 | Lesser of lines 53/54 or 55 from the cost rep | porting period | ending 1996, u | pdated and co | ompounded by the | | |
| | market basket | 0 1 | Ū | | . , | | |
|). 00 . 00 | Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines | | | | the amount by | 0.00 | |
| . 00 | which operating costs (line 53) are less than | | | | | | יסן |
| | amount (line 56), otherwise enter zero (see i | | | 00), 01 1,8 01 | the target | | |
| 2.00 | Relief payment (see instructions) | | | | | 0 | |
| 8.00 | Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST | ent (see instru | ctions) | | | C |) 63 |
| . 00 | Medicare swing-bed SNF inpatient routine cost | ts through Dece | mber 31 of the | cost reporti | ng period (See | C | 64 |
| | instructions)(title XVIII only) | | | | | | |
| 5.00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) | ts after Decemb | er 31 of the c | ost reporting | period (See | C |) 65 |
| 5.00 | Total Medicare swing-bed SNF inpatient routir | ne costs (line | 64 plus line 6 | 5)(title XVII | l onlv). For | c c | 66 |
| | CAH (see instructions) | | | | 57 | | |
| 7.00 | Title V or XIX swing-bed NF inpatient routine | e costs through | December 31 c | f the cost re | eporting period | 0 | 67 |
| 3. 00 | (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine | e costs after D | ecember 31 of | the cost repo | orting period | c | 68 |
| 5.00 | (line 13 x line 20) | | | the cost rept | in this period | Ĭ | |
| 9.00 | Total title V or XIX swing-bed NF inpatient r | | | | | 0 |) 69 |
| 00 | PART III - SKILLED NURSING FACILITY, OTHER NU | | | | | | |
|). 00 . 00 | Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co | | | | | | 70 |
| . 00 | Program routine service cost (line 9 x line 7 | | | | | 1 | 72 |
| 8.00 | Medically necessary private room cost applica | | | | | | 73 |
| . 00 | Total Program general inpatient routine servi | | , | | | | 74 |
| 5.00 | Capital-related cost allocated to inpatient r 26, line 45) | outine service | CUSIS (FROM W | UIKSNEET B, H | aitii, column | | 75 |
| . 00 | Per diem capital-related costs (line 75 ÷ lir | ne 2) | | | | 1 | 76 |
| . 00 | Program capital-related costs (line 9 x line | | | | | | 77 |
| . 00 | Inpatient routine service cost (line 74 minus | | rovi don noor | | | | 78 |
| . 00 . 00 | Aggregate charges to beneficiaries for excess Total Program routine service costs for compa | | | | nus line 70) | 1 | 80 |
| . 00 | Inpatient routine service costs for compa | | | | | 1 | 81 |
| . 00 | Inpatient routine service cost limitation (li | |) | | | 1 | 82 |
| . 00 | Reasonable inpatient routine service costs (s | | s) | | | | 83 |
| . 00 | Program inpatient ancillary services (see ins | | nc) | | | | 84 |
| 5.00 5.00 | Utilization review - physician compensation (Total Program inpatient operating costs (sum | | | | | | 85 |
| | PART IV - COMPUTATION OF OBSERVATION BED PASS | | | | | | |
| . 00 | Total observation bed days (see instructions) | | | | | 491 | |
| 3.00 | Adjusted general inpatient routine cost per o | | | | | 1, 201. 82 | |

| Health Financial Systems Fi | AYETTE REGIONAL | HEALTH SYSTEM | | In Lieu of Form CMS-2552 | | | |
|---|-----------------|----------------|----------------------------|--------------------------|----------------|-------|--|
| COMPUTATION OF INPATIENT OPERATING COST | Provider CC | | Period: From 10/01/2017 | Worksheet D-1 | | | |
| | | | | To 09/30/2018 | | | |
| | | | 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 | 249, 311 | 4, 205, 180 | 0. 05928 | 7 590, 094 | 34, 985 | 90.00 | |
| 91.00 Nursing School cost | 0 | 4, 205, 180 | 0.00000 | 590, 094 | 0 | 91.00 | |
| 92.00 Allied health cost | 0 | 4, 205, 180 | 0.00000 | 590, 094 | 0 | 92.00 | |
| 93.00 All other Medical Education | 0 | 4, 205, 180 | 0.00000 | 590, 094 | 0 | 93.00 | |

| MPUT | TION OF INPATIENT OPERATING COST | Provider CCN: 15-0064 Component CCN: 15-S064 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 Date/Time Pre 2/28/2019 1:0 | pare | |
|----------|---|---|---|---|----------|--|
| | | Title XVIII | Subprovider - IPF | PPS | | |
| | Cost Center Description | | | | | |
| | PART I - ALL PROVIDER COMPONENTS | | 1 | 1.00 | | |
| | INPATIENT DAYS Inpatient days (including private room days and swing-bed da | vs excluding newborn) | | 303 | 1. | |
| | Inpatient days (including private room days, excluding swing-bed days) | | | 303 | 2. | |
| 00 | Private room days (excluding swing-bed and observation bed d | | ivate room days, | 0 | 3. | |
| | do not complete this line. | | | | | |
| 00 00 | Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private ro | | r 31 of the cost | 303 0 | 4. 5. | |
| 00 | reporting period | com days) thi odgi becembe | 1 51 01 the cost | 0 | | |
| 00 | Total swing-bed SNF type inpatient days (including private r | oom days) after December | 31 of the cost | 0 | 6. | |
| ~~ | reporting period (if calendar year, enter 0 on this line) | | 01 6 11 | 0 | _ | |
| 00 | Total swing-bed NF type inpatient days (including private ro reporting period | om days) through December | 31 of the cost | 0 | 7. | |
| 00 | Total swing-bed NF type inpatient days (including private ro | om days) after December 3 | 1 of the cost | 0 | 8. | |
| | reporting period (if calendar year, enter 0 on this line) | | | | | |
| 00 | Total inpatient days including private room days applicable newborn days) | to the Program (excluding | swing-bed and | 264 | 9. | |
| 0. 00 | Swing-bed SNF type inpatient days applicable to title XVIII | onlv (including private r | oom davs) | 0 | 10 | |
| | through December 31 of the cost reporting period (see instru | ctions) | • | | | |
| . 00 | Swing-bed SNF type inpatient days applicable to title XVIII | | oom days) after | 0 | 11 | |
| 00 | December 31 of the cost reporting period (if calendar year, s Swing-bed NF type inpatient days applicable to titles V or X | | e room days) | 0 | 12 | |
| . 00 | through December 31 of the cost reporting period | in only (the daring privat | c room days) | 0 | '2 | |
| 3. 00 | Swing-bed NF type inpatient days applicable to titles V or X | | | 0 | 13 | |
| 00 | after December 31 of the cost reporting period (if calendar) Medically necessary private room days applicable to the Prog | | | 0 | 14 | |
| | Total nursery days (title V or XIX only) | ram (excluding swing-bed | uays) | 0 | 14 | |
| - | Nursery days (title V or XIX only) | | | 0 | 16 | |
| | SWING BED ADJUSTMENT | | 1 | | | |
| . 00 | Medicare rate for swing-bed SNF services applicable to servi- reporting period | ces through December 31 o | f the cost | 0.00 | 17 | |
| 3. 00 | Medicare rate for swing-bed SNF services applicable to servi | ces after December 31 of | the cost | 0.00 | 18 | |
| | reporting period | | | | | |
| 9. 00 | Medicaid rate for swing-bed NF services applicable to servic | es through December 31 of | the cost | 0.00 | 19 | |
| 00 | reporting period Medicaid rate for swing-bed NF services applicable to servic | es after December 31 of t | he cost | 0.00 | 20 | |
| . 00 | reporting period | | | 0.00 | 20 | |
| | Total general inpatient routine service cost (see instruction | | | 636, 521 | | |
| 2. 00 | Swing-bed cost applicable to SNF type services through Decem 5 x line 17) | ber 31 of the cost report | ing period (line | 0 | 22 | |
| 00 | Swing-bed cost applicable to SNF type services after Decembe | r 31 of the cost reportin | a period (line 6 | 0 | 23 | |
| | x line 18) | · · · · · · · · · · · · · · · · · · · | 9 p = : : = = (: : : = = | - | | |
| . 00 | Swing-bed cost applicable to NF type services through Decemb | er 31 of the cost reporti | ng period (line | 0 | 24 | |
| . 00 | 7 x line 19) Swing-bed cost applicable to NF type services after December | 31 of the cost reporting | period (line 8 | 0 | 25 | |
| . 00 | x line 20) | ST OF the cost reporting | period (inne o | 0 | 23 | |
| | Total swing-bed cost (see instructions) | | | 0 | 26 | |
| | General inpatient routine service cost net of swing-bed cost | (line 21 minus line 26) | | 636, 521 | 27 | |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b | ed and observation bed ch | arges) | 0 | 28 | |
| | Private room charges (excluding swing-bed charges) | | al gooy | 0 | 29 | |
| 0. 00 | Semi-private room charges (excluding swing-bed charges) | | | 0 | 30 | |
| | General inpatient routine service cost/charge ratio (line 27 | ÷line 28) | | 0.000000 | 31 | |
| | Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) | | | 0.00 0.00 | 32 | |
| | Average per diem private room charge differential (line 32 m | inus line 33)(see instruc | tions) | 0.00 | 34 | |
| 5.00 | Average per diem private room cost differential (line 34 x l | | - | 0.00 | 35 | |
| | Private room cost differential adjustment (line 3 x line 35) | and polycets and the " | fforontial (1) | 0 | 36 | |
| . 00 | General inpatient routine service cost net of swing-bed cost 27 minus line 36) | and private room cost di | TTEPENTIAL (LINE | 636, 521 | 37 | |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. | | | | | |
| | Adjusted general inpatient routine service cost per diem (se | | | 2, 100. 73 | 38 | |
| | Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Prog | | | 554, 593 0 | 39 40 | |
| | WEAR AGE V DECENDED VIEW ATE FOUN CONT ADDITICATE TO THE PEOD | 1 ann (11110 14 X 11110 33) | | 0 | 1 4U | |

| | Financial Systems Fi ATION OF INPATIENT OPERATING COST | YETTE REGIONAL | | CCN: 15-0064 | Peri od: | eu of Form CMS- Worksheet D-1 | |
|----------------|---|-----------------|----------------|---------------------------|----------------------------------|----------------------------------|----------|
| | | | Component | CCN: 15-S064 | From 10/01/2017 To 09/30/2018 | Date/Time Pre | |
| | | | Ti tl | e XVIII | Subprovi der - | 2/28/2019 1:0 PPS | 02 pm |
| | Cost Center Description | Total | Total | Average Pe | r Program Days | Program Cost | |
| | · | Inpatient Cost | Inpatient Day | rsDiem (col. ´ col. 2) | l÷ | (col. 3 x col. 4) | |
| 00 | NUDCEDV (+; + o V & VIV only) | 1.00 C | 2.00 | 3.00 | 4.00 | 5.00 |) 42. |
| . 00 | NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units | Ĺ | <u>л</u> | 0 0. | 00 0 | 1 0 | <u> </u> |
| . 00 | INTENSIVE CARE UNIT | C |) | 0 0. | 00 0 | C | |
| . 00 . 00 | CORONARY CARE UNIT BURN INTENSIVE CARE UNIT | | | | | | 44 |
| . 00 | SURGI CAL I NTENSI VE CARE UNI T | | | | | | 46 |
| . 00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | 47 |
| | Cost Center Description | | | | | 1.00 | |
| . 00 | Program inpatient ancillary service cost (Wk | | | | | 325, 108 | |
| . 00 | Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS | 11 through 48) | (see instructi | ons) | | 879, 701 | 49 |
| . 00 | Pass through costs applicable to Program inp | atient routine | services (fro | om Wkst. D, su | um of Parts I and | 68, 128 | 3 50 |
| | | | | | | | |
| . 00 | 00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV) | | | | | 7, 641 | 51 |
| 2. 00 | Total Program excludable cost (sum of lines | | | | | 75, 769 | |
| 3. 00 | Total Program inpatient operating cost exclumedical education costs (line 49 minus line | | elated, non-ph | nysi ci an anest | hetist, and | 803, 932 | 2 53 |
| | TARGET AMOUNT AND LIMIT COMPUTATION | 52) | | | | | |
| | Program di scharges | | | | | 0 | |
| . 00 . 00 | Target amount per discharge Target amount (line 54 x line 55) | | | | | 0.00 | |
| . 00 | Difference between adjusted inpatient operat | ng cost and ta | arget amount (| [line 56 minus | s line 53) | 0 | |
| . 00 | Bonus payment (see instructions) | - | - | | | 0 | |
| . 00 | Lesser of lines 53/54 or 55 from the cost re market basket | porting period | endi ng 1996, | updated and o | compounded by the | 0.00 | 59 |
| 0. 00 | Lesser of lines 53/54 or 55 from prior year | cost report, u | pdated by the | market basket | - | 0.00 | 60 |
| . 00 | If line 53/54 is less than the lower of line | | | | | 0 | 61 |
| | which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see | | ts (lines 54 x | (60), or 1% (| of the target | | |
| 2.00 | Relief payment (see instructions) | nati deti onaj | | | | 0 | 62 |
| 8. 00 | Allowable Inpatient cost plus incentive paym | ent (see instru | uctions) | | | C | 63 |
| . 00 | PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos | ts through Dece | ember 31 of th | e cost report | ing period (See | |) 64 |
| | instructions)(title XVIII only) | Ū. | | | 0. | | |
| 6. 00 | Medicare swing-bed SNF inpatient routine cos | ts after Decem | ber 31 of the | cost reportir | ng period (See | 0 |) 65 |
| . 00 | instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi | ne costs (line | 64 plus line | 65)(title XVI | ll only). For | C | 66 |
| | CAH (see instructions) | | | | 3, | | |
| . 00 | Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) | e costs throug | h December 31 | of the cost r | reporting period | C | 67 |
| 3. 00 | Title V or XIX swing-bed NF inpatient routin | e costs after l | December 31 of | f the cost rep | orting period | 0 | 68 |
| | (line 13 x line 20) | | (line (7 . lin | va (0) | | | |
| 9.00 | Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU | | | | | 0 |) 69 |
| 0. 00 | Skilled nursing facility/other nursing facil | ty/ICF/IID row | utine service | cost (line 37 | /) | | 70 |
| . 00 | Adjusted general inpatient routine service of | | line 70 ÷ line | 2) | | | 71 |
| . 00 | Program routine service cost (line 9 x line Medically necessary private room cost applic | | m (line 14 x l | ine 35) | | | 72 |
| . 00 | Total Program general inpatient routine serv | ce costs (line | e 72 + line 73 | 3) | | | 74 |
| 5.00 | Capital-related cost allocated to inpatient 26, line 45) | routine service | e costs (from | Worksheet B, | Part II, column | | 75 |
| . 00 | Per diem capital-related costs (line 75 ÷ li | ne 2) | | | | | 76 |
| . 00 | Program capital -related costs (line 9 x line | | | | | | 77 |
| . 00 . 00 | Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces | | provider recor | ds) | | | 78 |
| . 00 | Total Program routine service costs for comp | | | | nus line 79) | | 80 |
| . 00 | Inpatient routine service cost per diem limi | tation | | - | | | 81 |
| . 00 | Inpatient routine service cost limitation (I | | · · · · | | | | 82 |
| 3. 00 1. 00 | Reasonable inpatient routine service costs (Program inpatient ancillary services (see in | | 115) | | | | 83 |
| 5.00 | Utilization review - physician compensation | | ons) | | | | 85 |
| . 00 | Total Program inpatient operating costs (sum | | hrough 85) | | | | 86 |
| . 00 | PART IV - COMPUTATION OF OBSERVATION BED PAS: Total observation bed days (see instructions | | | | | 0 | 87 |
| 3.00 | Adjusted general inpatient routine cost per | | ÷line 2) | | | 0.00 | |
| | Observation bed cost (line 87 x line 88) (se | | | | | | 89 |

| Health Financial Systems F. | AYETTE REGIONAL | HEALTH SYSTEM | | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|--------------------------------|--------------|-------------------------------|----------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CO | | Period: From 10/01/2017 | Worksheet D-1 | |
| | | Component (| CCN: 15-S064 | To 09/30/2018 | Date/Time Prep 2/28/2019 1:02 | |
| | | Title | XVIII | Subprovider - IPF | PPS | |
| Cost Center Description | Cost | Routine Cost (from line 21) | column 1 ÷ | Total | Observation Bed Pass | |
| | | (ITOM TIME 21) | column 2 | Observation Bed Cost (from | | |
| | | | | | (col. 3 x col. | |
| | | | | TTHE 07) | 4) (see | |
| | | | | | instructions) | |
| | 1.00 | 2.00 | 3.00 | 4,00 | 5.00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | | 2.00 | 0.00 | 1.00 | 0.00 | |
| 90.00 Capital-related cost | 78, 192 | 636, 521 | 0. 12284 | 3 0 | 0 | 90.00 |
| 91.00 Nursing School cost | 0 | 636, 521 | 0. 00000 | 0 0 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 636, 521 | 0. 00000 | 0 0 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 636, 521 | 0. 00000 | 0 0 | 0 | 93.00 |

| | ATION OF INPATIENT OPERATING COST | Provider CCN: 15-0064 | Peri od: | Worksheet D-1 | |
|--|---|---|----------------------------------|---|--|
| | | Component CCN: 15-T064 | From 10/01/2017 To 09/30/2018 | Date/Time Prep 2/28/2019 1:02 | |
| | | Title XVIII | Subprovider - IRF | PPS | |
| | Cost Center Description | | - | 1.00 | |
| | PART I - ALL PROVIDER COMPONENTS | | 4 | | |
| . 00 | INPATIENT DAYS Inpatient days (including private room days and swing-bed d | lave oveluding nowhern) | | 0 | 1 1 |
| . 00 | Inpatient days (including private room days, excluding swing-bed d | | | 0 | 2 |
| . 00 | Private room days (excluding swing-bed and observation bed | 5 | ivate room days, | 0 | |
| | do not complete this line. | 5, 5, 5, | <u> </u> | | |
| . 00 | Semi-private room days (excluding swing-bed and observation | | | 0 | 4 |
| . 00 | Total swing-bed SNF type inpatient days (including private reporting period | room days) through Decembe | r 31 of the cost | 0 | 5 |
| . 00 | Total swing-bed SNF type inpatient days (including private | room davs) after December | 31 of the cost | 0 | 6 |
| | reporting period (if calendar year, enter 0 on this line) | | | - | |
| . 00 | Total swing-bed NF type inpatient days (including private r | oom days) through December | 31 of the cost | 0 | 7 |
| 00 | reporting period | | | | |
| . 00 | Total swing-bed NF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line) | 'oom days) after December 3 | I OF THE COST | 0 | 8 |
| . 00 | Total inpatient days including private room days applicable | e to the Program (excluding | swing-bed and | 0 | 9 |
| | newborn days) | 0 1 0 | Ū. | | |
| 0. 00 | Swing-bed SNF type inpatient days applicable to title XVIII | | oom days) | 0 | 10 |
| 1.00 | through December 31 of the cost reporting period (see instr Swing-bed SNF type inpatient days applicable to title XVIII | | nom dave) after | 0 | 11 |
| 1.00 | December 31 of the cost reporting period (if calendar year, | | oom days) arter | 0 | '' |
| 2.00 | Swing-bed NF type inpatient days applicable to titles V or | | e room days) | 0 | 12 |
| | through December 31 of the cost reporting period | | • | | |
| 3.00 | Swing-bed NF type inpatient days applicable to titles V or | | | 0 | 13 |
| 1 00 | after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Pro | | | 0 | 14 |
| | Total nursery days (title V or XIX only) | gram (excluding swrng-bed | uays) | 0 | 15 |
| | Nursery days (title V or XIX only) | | | 0 | 16 |
| | SWING BED ADJUSTMENT | | | | |
| 7.00 | Medicare rate for swing-bed SNF services applicable to serv | rices through December 31 o | f the cost | 0.00 | 17 |
| 8 00 | reporting period Medicare rate for swing-bed SNF services applicable to serv | vices after December 31 of | the cost | 0.00 | 18 |
| | reporting period | | | | |
| 9.00 | Medicaid rate for swing-bed NF services applicable to servi | ces through December 31 of | the cost | 0.00 | 19 |
| 0 00 | reporting period Medicaid rate for swing-bed NF services applicable to servi | and offer December 21 of t | he east | 0.00 | 2 |
| 0.00 | reporting period | ces al tel becember 31 01 t | ne cost | 0.00 | |
| 1.00 | Total general inpatient routine service cost (see instructi | ons) | | 0 | 21 |
| 2.00 | Swing-bed cost applicable to SNF type services through Dece | mber 31 of the cost report | ing period (line | 0 | 22 |
| | 5 x line 17) | | | | |
| | Swing-bed cost applicable to SNF type services after Decemb x line 18) | per 31 of the cost reportin | g period (line 6 | 0 | 23 |
| 3.00 | Swing-bed cost applicable to NF type services through Decem | ber 31 of the cost reporti | ng period (line | 0 | 24 |
| | Swing bed cost appricable to will type services through becch | | • • | | |
| 4.00 | 7 x line 19) | | | | |
| 4.00 | 7 x line 19) Swing-bed cost applicable to NF type services after Decembe | er 31 of the cost reporting | period (line 8 | 0 | 25 |
| 4. 00 5. 00 | 7 x line 19) Swing-bed cost applicable to NF type services after Decembe x line 20) | er 31 of the cost reporting | period (line 8 | | |
| 4.00 5.00 6.00 | 7 x line 19) Swing-bed cost applicable to NF type services after Decembe x line 20) Total swing-bed cost (see instructions) | | period (line 8 | 0 0 0 | 26 |
| 4. 00 5. 00 6. 00 | 7 x line 19) Swing-bed cost applicable to NF type services after Decembe x line 20) | | period (line 8 | 0 | 26 |
| 4.00 5.00 6.00 7.00 8.00 | 7 x line 19) Swing-bed cost applicable to NF type services after Decembe x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cos PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing- | t (line 21 minus line 26) | | 0 0 | 26 27 28 |
| 4.00 5.00 6.00 7.00 8.00 9.00 | 7 x line 19) Swing-bed cost applicable to NF type services after Decembe x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cos PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing- Private room charges (excluding swing-bed charges) | t (line 21 minus line 26) | | 0 0 0 0 0 | 26 27 28 29 |
| 4.00 5.00 6.00 7.00 8.00 9.00 0.00 | 7 x line 19) Swing-bed cost applicable to NF type services after Decembe x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cos PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing- Private room charges (excluding swing-bed charges) Semi -private room charges (excluding swing-bed charges) | t (line 21 minus line 26) bed and observation bed ch | | 0 0 0 0 0 0 | 26 27 28 29 30 |
| 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 | 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing- Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 2 | t (line 21 minus line 26) bed and observation bed ch | | 0 0 0 0 0 0 0.000000 | 26 27 28 29 30 31 |
| 4.00 5.00 6.00 7.00 3.00 9.00 0.00 1.00 2.00 | 7 x line 19) Swing-bed cost applicable to NF type services after Decembe x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cos PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing- Private room charges (excluding swing-bed charges) Semi -private room charges (excluding swing-bed charges) | t (line 21 minus line 26) bed and observation bed ch 7 ÷ line 28) | | 0 0 0 0 0 0 | 26 27 28 29 30 31 32 |
| 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 | 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing- Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 2 Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge differential (line 32 | t (line 21 minus line 26) bed and observation bed ch 7 ÷ line 28) minus line 33)(see instruct | arges) | 0 0 0 0 0.000000 0.000000 0.000 0.000 0.000 0.000 | 26 27 28 29 30 31 32 33 34 |
| 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 | 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing- Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 2 Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge differential (line 32 Average per diem private room cost differential (line 34 x | t (line 21 minus line 26) bed and observation bed ch 7 ÷ line 28) minus line 33)(see instruct line 31) | arges) | 0 0 0 0 0.000000 0.000000 0.00 0.00 0. | 26 27 28 29 30 31 32 33 34 35 |
| 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 | 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing- Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 2 Average private room per diem charge (line 29 ÷ line 3) Average per diem private room cost differential (line 32 Average per diem private room cost differential (line 34 x Private room cost differential adjustment (line 3 x line 35 | t (line 21 minus line 26) bed and observation bed ch 7 ÷ line 28) minus line 33)(see instruc line 31) | arges) ti ons) | 0 0 0 0 0.000000 0.00 0.00 0.00 0.00 0 | 26 27 28 29 30 31 32 33 34 35 36 |
| 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 | 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed coss PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing- Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 2 Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4 Average per diem private room cost differential (line 34 x Private room cost differential adjustment (line 3 x line 35 General inpatient routine service cost net of swing-bed cos | t (line 21 minus line 26) bed and observation bed ch 7 ÷ line 28) minus line 33)(see instruc line 31) | arges) ti ons) | 0 0 0 0 0.000000 0.000000 0.00 0.00 0. | 26 27 28 29 30 31 32 33 34 35 36 |
| 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 | 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing- Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 2 Average private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 32 Average per diem private room cost differential (line 34 x Private room cost differential adjustment (line 3 x line 35 General inpatient routine service cost net of swing-bed cos 27 minus line 36) | t (line 21 minus line 26) bed and observation bed ch 7 ÷ line 28) minus line 33)(see instruc line 31) | arges) ti ons) | 0 0 0 0 0.000000 0.00 0.00 0.00 0.00 0 | 26 27 28 29 30 31 32 33 34 35 36 |
| 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 | 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed coss PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing- Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 2 Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4 Average per diem private room cost differential (line 34 x Private room cost differential adjustment (line 3 x line 35 General inpatient routine service cost net of swing-bed cos | t (line 21 minus line 26) bed and observation bed ch 7 ÷ line 28) minus line 33)(see instruc line 31) t and private room cost di | arges) ti ons) | 0 0 0 0 0.000000 0.00 0.00 0.00 0.00 0 | 26 27 28 29 30 31 32 33 34 35 36 |
| 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 | 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing- Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 2 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4 Average per diem private room cost differential (line 32 x Private room cost differential adjustment (line 3 x line 35 General inpatient routine service cost net of swing-bed cos 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST A Adjusted general inpatient routine service cost per diem (s | t (line 21 minus line 26) bed and observation bed ch 7 ÷ line 28) minus line 33)(see instructions) t and private room cost di DJUSTMENTS tee instructions) | arges) ti ons) | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 26 27 28 29 30 31 32 33 34 35 36 37 38 |
| 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 6.00 7.00 8.00 9.00 | 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing- Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 2 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4 Average per diem private room cost differential (line 34 x Private room cost differential adjustment (line 3 x line 35 General inpatient routine service cost net of swing-bed cos 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST A | t (line 21 minus line 26) bed and observation bed ch 7 ÷ line 28) minus line 33)(see instruct line 31) t and private room cost di DJUSTMENTS tee instructions) ne 38) | arges) ti ons) | 0 0 0 0 0.000000 0.000 0.00 0.00 0.00 | 28 29 30 31 32 33 34 35 36 37 |

| | Financial Systems FA | YETTE REGIONAL | | CN: 15-0064 | Peri od: | eu of Form CMS- Worksheet D-1 | |
|----------------|--|------------------|-----------------|----------------|----------------------------------|----------------------------------|-------------------|
| | | | Component | CCN: 15-T064 | From 10/01/2017 To 09/30/2018 | Date/Time Pre | |
| | | | Title | e XVIII | Subprovider - | 2/28/2019 1:0 PPS | <u>)2 pm</u> |
| | Cost Center Description | Total | Total | Average Per | IRF Program Days | Program Cost | |
| | | Inpatient Costl | | col . 2) | ÷ | (col. 3 x col. 4) | |
| 2.00 | NURSERY (title V & XIX only) | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 |) 42. |
| . 00 | Intensive Care Type Inpatient Hospital Units | | | 0. | 00 0 | 1 | , 12. |
| | INTENSIVE CARE UNIT | 0 | C | 0. | 00 0 | 0 0 | |
| . 00 | CORONARY CARE UNIT BURN INTENSIVE CARE UNIT | | | | | | 44. |
| | SURGI CAL I NTENSI VE CARE UNI T | | | | | | 46. |
| . 00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | 47. |
| | Cost Center Description | | | | | 1.00 | |
| | Program inpatient ancillary service cost (Wks | | | | | C | |
| . 00 | Total Program inpatient costs (sum of lines / PASS THROUGH COST ADJUSTMENTS | 11 through 48)(| see instructio | ons) | | C | 49 |
| . 00 | Pass through costs applicable to Program inpa | atient routine : | services (from | n Wkst. D, su | m of Parts I and | 0 | 50 |
| | | | | | | | |
| . 00 | Pass through costs applicable to Program inpa and IV) | atient anciiiar | y services (Tr | OM WKST. D, | sum of Parts II | C |) 51 |
| 2.00 | Total Program excludable cost (sum of lines ! | | | | | 0 | |
| 3.00 | Total Program inpatient operating cost exclud | | lated, non-phy | vsician anest | hetist, and | C | 53 |
| | medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION | 52) | | | | | |
| . 00 | Program di scharges | | | | | 0 | 54 |
| | Target amount per discharge | | | | | 0.00 | |
| . 00 . 00 | Target amount (line 54 x line 55) | ng cost and ta | raot amount (1 | ino E4 minuc | Lino E2) | | |
| . 00 | Difference between adjusted inpatient operati Bonus payment (see instructions) | ng cost and ta | iget amount (i | The so minus | TTHE 55) | | |
| . 00 | Lesser of lines 53/54 or 55 from the cost rep | orting period (| ending 1996, ι | pdated and c | ompounded by the | | |
| | market basket | | | | | 0.00 | |
|). 00 . 00 | Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines | | | | the amount by | 0.00 | |
| . 00 | which operating costs (line 53) are less than | | | | | | |
| | amount (line 56), otherwise enter zero (see i | nstructions) | | | | | |
| | Relief payment (see instructions) Allowable Inpatient cost plus incentive payme | ont (coo instru | ations) | | | | |
| 5.00 | PROGRAM INPATIENT ROUTINE SWING BED COST | | | | | | 03 |
| . 00 | Medicare swing-bed SNF inpatient routine cos | ts through Dece | mber 31 of the | e cost report | ing period (See | C | 64 |
| 5.00 | instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos | ts after Decemb | er 31 of the c | ost reportin | n neriod (See | c | 65 |
| . 00 | instructions) (title XVIII only) | | | ust reportin | g period (see | | |
| 5.00 | Total Medicare swing-bed SNF inpatient routin | ne costs (line d | 64 plus line 6 | 5)(title XVI | II only). For | C | 66 |
| 7.00 | CAH (see instructions) Title V or XIX swing-bed NF inpatient routing | costs through | December 31 c | of the cost r | eporting period | 0 | 67 |
| . 00 | (line 12 x line 19) | e costs through | December 51 C | in the cost is | eporting period | | / ⁰ / |
| 3. 00 | Title V or XIX swing-bed NF inpatient routine | e costs after De | ecember 31 of | the cost rep | orting period | C | 68 (|
| 9.00 | (line 13 x line 20) Total title V or XIX swing-bed NF inpatient n | coutine costs (| line 67 + line | 68) | | | 69 |
| . 00 | PART III - SKILLED NURSING FACILITY, OTHER NU | | | | | | 107 |
| 0. 00 | Skilled nursing facility/other nursing facili | ty/ICF/IID rou | tine service c | ost (line 37 |) | | 70 |
| | Adjusted general inpatient routine service of | | ine 70 ÷ line | 2) | | | 71 |
| | Program routine service cost (line 9 x line 7 Medically necessary private room cost applica | | (line 14 x li | ne 35) | | | 72 |
| | Total Program general inpatient routine servi | | | | | | 74 |
| 5.00 | Capital-related cost allocated to inpatient i | routine service | costs (from W | lorksheet B, | Part II, column | | 75 |
| . 00 | 26, line 45) Per diem capital-related costs (line 75 ÷ lin | ne 2) | | | | | 76 |
| . 00 | Program capital-related costs (line 9 x line | 76) | | | | | 77 |
| | Inpatient routine service cost (line 74 minus | | rovi dor rocorr | | | | 78 |
| | Aggregate charges to beneficiaries for excess Total Program routine service costs for compa | | | | nus line 79) | | 79 80 |
| | Inpatient routine service cost per diem limi | | | (| | | 81 |
| | Inpatient routine service cost limitation (li | | | | | | 82 |
| . 00 | Reasonable inpatient routine service costs (s | | s) | | | | 83 |
| . 00 . 00 | Program inpatient ancillary services (see ins Utilization review - physician compensation | | ns) | | | | 84 |
| | Total Program inpatient operating costs (sum | | | | | | 86 |
| | PART IV - COMPUTATION OF OBSERVATION BED PASS | THROUGH COST | | | | 1 | |
| 7.00 | Total observation bed days (see instructions) Adjusted general inpatient routine cost per o | | line 2 | | | 0.00 | |
| 3.00 | AND AN AND A DECEMBER AND TODALLED COUTINE COST NET (| | | | | i U. U. | 88. |

| Health Financial Systems F. | AYETTE REGIONAL | HEALTH SYSTEM | | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|--------------------------------|------------------------|--|---|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider C | | Period: From 10/01/2017 | Worksheet D-1 | |
| | | Component (| CCN: 15-T064 | To 09/30/2018 | Date/Time Pre 2/28/2019 1:0 | |
| | | Title | XVIII | Subprovider - IRF | PPS | |
| Cost Center Description | Cost | Routine Cost (from line 21) | column 1 ÷ column 2 | Total Observation Bed Cost (from line 89) | Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 90.00 Capital -related cost | 0 | 0 | 0.00000 | 0 00 | 0 | 90.00 |
| 91.00 Nursing School cost | 0 | 0 | 0.00000 | | 0 | |
| 92.00 Allied health cost 93.00 All other Medical Education | 0 | 0 0 | 0.00000 | | 0 | 92.00 93.00 |

| FAYETTE | REGI ONAL | HEALTH | SYS | TEM | |
|---------|-----------|--------|-----|-----|------|
| | | - | | | |

| Heal th | Financial Systems FAYETTE REGIONAL HI | EALTH SYSTEM | In Lie | u of Form CMS-2 | 2552-10 |
|------------------|---|--------------------------|----------------------------------|----------------------------------|----------------|
| | ATION OF INPATIENT OPERATING COST | Provider CCN: 15-0064 | Peri od: | Worksheet D-1 | |
| | | | From 10/01/2017 To 09/30/2018 | Date/Time Prep 2/28/2019 1:02 | pared: 2 pm |
| | | Title XIX | Hospi tal | Cost | |
| | Cost Center Description | | | 1.00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | 1.00 | |
| | INPATIENT DAYS | | | | |
| 1.00 | Inpatient days (including private room days and swing-bed day | | | 3, 499 | |
| 2.00 3.00 | Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da do not complete this line. | | ivate room days, | 3, 499 0 | |
| 4.00 5.00 | Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro | | er 31 of the cost | 3, 008 0 | |
| 6.00 | reporting period Total swing-bed SNF type inpatient days (including private ro | om days) after December | 31 of the cost | 0 | 6.00 |
| 7.00 | reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo reporting period | m days) through December | 31 of the cost | 0 | 7.00 |
| 8.00 | Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line) | m days) after December 3 | 1 of the cost | 0 | 8.00 |
| 9.00 | Total inpatient days including private room days applicable to newborn days) | o the Program (excluding | swing-bed and | 71 | 9.00 |
| 10.00 | Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc | tions) | 5 | 0 | |
| 11. 00 12. 00 | Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI | nter 0 on this line) | 5 | 0 | |
| 12.00 | through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V of XI. | <u> </u> | 5, | 0 | |
| 14.00 | after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr | ear, enter O on this lir | ie) | 0 | |
| 15.00 | Total nursery days (title V or XIX only) | | | 333 | |
| 16.00 | Nursery days (title V or XIX only) | | | 0 | 16.00 |
| 17.00 | SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic reporting period | es through December 31 c | f the cost | 0.00 | 17.00 |
| 18.00 | Medicare rate for swing-bed SNF services applicable to servic reporting period | es after December 31 of | the cost | 0.00 | 18.00 |
| 19. 00 | Medicaid rate for swing-bed NF services applicable to service reporting period | 0 | | | 19.00 |
| 20.00 | Medicaid rate for swing-bed NF services applicable to service reporting period | | he cost | | 20.00 |
| 21. 00 22. 00 | Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb 5 x line 17) | | ing period (line | 4, 205, 180 0 | 21.00 |
| 23.00 | Swing-bed cost applicable to SNF type services after December x line 18) | 31 of the cost reportir | g period (line 6 | 0 | 23.00 |
| 24.00 | Swing-bed cost applicable to NF type services through Decembe 7 x line 19) $% \left({\left[{{{\rm{T}}_{\rm{T}}} \right]_{\rm{T}}} \right)$ | • | | 0 | |
| 25.00 | Swing-bed cost applicable to NF type services after December x line 20) | 31 of the cost reporting | period (line 8 | 0 | |
| 26. 00 27. 00 | Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | (line 21 minus line 26) | | 0 4, 205, 180 | |
| 28.00 | General inpatient routine service charges (excluding swing-be | d and observation bed ch | arges) | 0 | 28.00 |
| 29.00 | Private room charges (excluding swing-bed charges) | | 5 / | 0 | |
| 30.00 | Semi-private room charges (excluding swing-bed charges) | | | 0 | |
| 31.00 | General inpatient routine service cost/charge ratio (line 27 | ÷line 28) | | 0.00000 | |
| 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 mi | nus line 33)(see instruc | tions) | 0.00 | 34.00 |
| 35.00 | Average per diem private room cost differential (line 34 x li | ne 31) | | 0.00 | |
| 36. 00 37. 00 | Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost | and private room cost di | fferential (line | 0 4, 205, 180 | 36.00 37.00 |
| | 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJI | | | | |
| 38.00 | Adjusted general inpatient routine service cost per diem (see | | | 1, 201. 82 | |
| 39.00 | Program general inpatient routine service cost (line 9 x line | | | 85, 329 | |
| 40. 00 41. 00 | Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39 | | | 0 85, 329 | |

| OMPUT | ATION OF INPATIENT OPERATING COST | | Provider C | | Period: From 10/01/2017 | Worksheet D-1 | 1 |
|--------------|--|------------------|-----------------|-----------------|----------------------------|-----------------------|------------|
| | | | | | To 09/30/2018 | Date/Time Pre | |
| | | | | e XIX | Hospi tal | 2/28/2019 1:0 Cost | 02 pr |
| | Cost Center Description | Total | Total | Average Per | | Program Cost | |
| | | Inpatient Cost | Inpatient Days | | ÷ | (col. 3 x col. | |
| | | 1.00 | 2.00 | col. 2) 3.00 | 4.00 | 4) 5.00 | + |
| 2. 00 | NURSERY (title V & XIX only) | 676, 601 | 333 | | | |) 42. |
| | Intensive Care Type Inpatient Hospital Units | | | | | | |
| . 00 | INTENSIVE CARE UNIT | 1, 834, 977 | 204 | 8, 994. 9 | 09 0 | 0 | |
| . 00 | CORONARY CARE UNI T BURN INTENSIVE CARE UNI T | | | | | | 44 |
| . 00 | SURGI CAL I NTENSI VE CARE UNI T | | | | | | 40 |
| . 00 | | | | | | | 47 |
| | Cost Center Description | | | | | | |
| . 00 | Program inpatient ancillary service cost (Wks | at D-3 col 3 | line 200) | | | 1.00 211,813 | 3 48 |
| . 00 | Total Program inpatient costs (sum of lines 4 | | | ns) | | 297, 142 | |
| | PASS THROUGH COST ADJUSTMENTS | | | | | 2777112 | |
| . 00 | Pass through costs applicable to Program inpa | atient routine | services (from | Wkst. D, sum | of Parts I and | 0 | 50 |
| 00 |) Dass through costs applicable to Drogram input | tiont ancillar | v corvioco (fr | om Wkat D a | um of Dorte II | 0 | 5 |
| . 00 | Pass through costs applicable to Program inpa and IV) | attent and than | y services (II | UNI WKSL. D, S | uni of Parts II | 0 | 51 |
| . 00 | Total Program excludable cost (sum of lines 5 | 50 and 51) | | | | 0 | 52 |
| . 00 | Total Program inpatient operating cost exclud | | lated, non-phy | sician anesth | etist, and | 0 | 53 |
| | medical education costs (line 49 minus line 5 | 52) | | | | | |
| . 00 | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges | | | | | 0 | 54 |
| . 00 | Target amount per discharge | | | | | 0.00 | |
| . 00 | Target amount (line 54 x line 55) | | | | | 0 | |
| . 00 | Difference between adjusted inpatient operati | ng cost and ta | rget amount (I | ine 56 minus | line 53) | 0 | |
| 3.00 9.00 | Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep | porting period | onding 1006 u | ndated and co | mounded by the | 0.00 | |
| . 00 | market basket | bor tring period | chung 1770, u | | inpounded by the | 0.00 | / 3/ |
| 0. 00 | Lesser of lines 53/54 or 55 from prior year of | | | | | 0.00 | |
| I. 00 | If line 53/54 is less than the lower of lines | | | | | 0 | 61 |
| | which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i | | s (TTHES 54 X | 60), 01 1% 01 | the target | | |
| 2. 00 | Relief payment (see instructions) | no tr do tr ono) | | | | 0 | 62 |
| . 00 | Allowable Inpatient cost plus incentive payme | ent (see instru | ctions) | | | 0 | 63 |
| 00 | PROGRAM INPATIENT ROUTINE SWING BED COST | to through Doop | mbor 21 of the | aget reporti | ng partiad (Caa | 0 | |
| . 00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) | is through bece | | cost reporti | ng period (see | 0 | 64 |
| 5.00 | Medicare swing-bed SNF inpatient routine cost | ts after Decemb | er 31 of the c | ost reporting | period (See | 0 | 65 |
| | instructions)(title XVIII only) | | | | | _ | |
| 6.00 | Total Medicare swing-bed SNF inpatient routir CAH (see instructions) | ne costs (line | 64 plus line 6 | 5)(title XVII | l only). For | 0 | 66 |
| . 00 | Title V or XIX swing-bed NF inpatient routine | e costs through | December 31 o | f the cost re | porting period | 0 | 67 |
| | (line 12 x line 19) | 5 | | | 1 51 | _ | |
| 3. 00 | Title V or XIX swing-bed NF inpatient routine | e costs after D | ecember 31 of | the cost repo | rting period | 0 | 68 |
| . 00 | (line 13 x line 20) Total title V or XIX swing-bed NF inpatient r | coutine costs (| line 67 + line | 68) | | 0 | 69 |
| . 00 | PART III - SKILLED NURSING FACILITY, OTHER NU | | | | | | 1 01 |
| . 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 | | ine 70 ÷ line | 2) | | | 71 |
| . 00 . 00 | Program routine service cost (line 9 x line 7 Medically necessary private room cost application | | (ling 14 v li | no 35) | | | 72 |
| . 00 | Total Program general inpatient routine servi | | | ne 33) | | | 74 |
| . 00 | Capital-related cost allocated to inpatient r | routine service | costs (from Ŵ | orksheet B, P | art II, column | | 75 |
| 00 | 26, line 45) | | | | | | _ . |
| . 00 . 00 | Per diem capital-related costs (line 75 ÷ lir Program capital-related costs (line 9 x line | | | | | | 76 |
| . 00 | Inpatient routine service cost (line 74 minus | | | | | | 78 |
| . 00 | Aggregate charges to beneficiaries for excess | , | rovi der record | s) | | | 79 |
| 00 | Total Program routine service costs for compa | | ost limitation | (line 78 min | us line 79) | | 80 |
| . 00 | Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li | |) | | | | 81 |
| . 00 | Reasonable inpatient routine service cost (| | • | | | | 82 |
| . 00 | Program inpatient ancillary services (see ins | | - / | | | | 84 |
| . 00 | Utilization review - physician compensation (| (see instructio | | | | | 85 |
| . 00 | Total Program inpatient operating costs (sum | | rough 85) | | | | 86 |
| . 00 | PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions) | | | | | 491 | 87 |
| | | | | | | 1, 201. 82 | |
| 3.00 | Adjusted general inpatient routine cost per o | alem (line ∠/÷ | line 2) | | | 1,201.02 | 00 |

| Health Financial Systems Fi | AYETTE REGIONAL | HEALTH SYSTEM | | In Lieu of Form CMS-2 | | | |
|---|-----------------|----------------|------------|----------------------------|----------------|----------------|--|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CC | | Period: From 10/01/2017 | Worksheet D-1 | | |
| | | | | To 09/30/2018 | | pared: 2 pm | |
| | | Titl | e XIX | Hospi tal | Cost | | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observati on | | |
| | | (from line 21) | column 2 | Observati on | Bed Pass | | |
| | | | | Bed Cost (from | Through Cost | | |
| | | | | line 89) | (col. 3 x col. | | |
| | | | | | 4) (see | | |
| | | | | | instructions) | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | | |
| 90.00 Capital-related cost | 249, 311 | 4, 205, 180 | 0. 05928 | 7 590, 094 | 34, 985 | 90.00 | |
| 91.00 Nursing School cost | 0 | 4, 205, 180 | 0.00000 | 590, 094 | 0 | 91.00 | |
| 92.00 Allied health cost | 0 | 4, 205, 180 | 0.00000 | 590, 094 | 0 | 92.00 | |
| 93.00 All other Medical Education | 0 | 4, 205, 180 | 0.00000 | 590, 094 | 0 | 93.00 | |

| OMPUT | ATION OF INPATIENT OPERATING COST | Provider CCN: 15-0064 | Period: | Worksheet D-1 | |
|-------|--|----------------------------|----------------------------------|--------------------------------|------|
| | | Component CCN: 15-SO64 | From 10/01/2017 To 09/30/2018 | Date/Time Pre 2/28/2019 1:0 | |
| | | Title XIX | Subprovider - IPF | Cost | |
| | Cost Center Description | | - | 1.00 | |
| | PART I – ALL PROVIDER COMPONENTS | | | | |
| | INPATIENT DAYS | | | | |
| 00 | Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing- | | | 303 303 | |
| 00 | Private room days (excluding swing-bed and observation bed da | | ivate room davs | 303 0 | |
| 00 | do not complete this line. | ays). Thi you have only pr | rvate room days, | 0 | . |
| 00 | Semi-private room days (excluding swing-bed and observation k | bed days) | | 303 | 4. |
| 00 | Total swing-bed SNF type inpatient days (including private ro | oom days) through Decembe | r 31 of the cost | 0 | 5 |
| | reporting period | | | 0 | |
| 00 | Total swing-bed SNF type inpatient days (including private ro | oom days) after December | 31 of the cost | 0 | 6 |
| 00 | reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo | om davs) through December | 31 of the cost | 0 | 7 |
| 00 | reporting period | on days) thi odgn becember | ST OF the cost | 0 | ' |
| 00 | Total swing-bed NF type inpatient days (including private roo | om days) after December 3 | 1 of the cost | 0 | 8 |
| | reporting period (if calendar year, enter 0 on this line) | 5 | | | |
| 00 | Total inpatient days including private room days applicable t | to the Program (excluding | swing-bed and | 6 | 9 |
| | newborn days) | | | 0 | 10 |
| . 00 | Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct | | oom days) | 0 | 10 |
| . 00 | Swing-bed SNF type inpatient days applicable to title XVIII of | | oom davs) after | 0 | 11 |
| | December 31 of the cost reporting period (if calendar year, e | | com dago) areor | Ũ | |
| 2. 00 | Swing-bed NF type inpatient days applicable to titles V or XI | | e room days) | 0 | 12 |
| | through December 31 of the cost reporting period | | | | |
| . 00 | Swing-bed NF type inpatient days applicable to titles V or XI | | | 0 | 13 |
| 00 | after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr | | | 0 | 14 |
| | Total nursery days (title V or XIX only) | all (excluding swing-bed | uays) | 333 | |
| | Nursery days (title V or XIX only) | | | 0 | |
| | SWING BED ADJUSTMENT | | 1 | - | |
| . 00 | Medicare rate for swing-bed SNF services applicable to service | ces through December 31 o | f the cost | 0.00 | 17 |
| | reporting period | | | | |
| 3.00 | Medicare rate for swing-bed SNF services applicable to servic | ces after December 31 of | the cost | 0.00 | 18 |
| 00 | reporting period Medicaid rate for swing-bed NF services applicable to service | es through December 31 of | the cost | 0.00 | 19 |
| . 00 | reporting period | es through becomber of or | | 0.00 | ' ' |
| 0. 00 | Medicaid rate for swing-bed NF services applicable to service | es after December 31 of t | he cost | 0.00 | 20 |
| | reporting period | | | | |
| | Total general inpatient routine service cost (see instruction | · | | 636, 521 | |
| 2.00 | Swing-bed cost applicable to SNF type services through Decemb | ber 31 of the cost report | ing period (line | 0 | 22 |
| 2 00 | 5 x line 17) Swing-bed cost applicable to SNF type services after December | r 31 of the cost reportin | a period (line 6 | 0 | 23 |
| 5.00 | x line 18) | ST OF the cost reporting | g period (inte o | 0 | 23 |
| 4.00 | Swing-bed cost applicable to NF type services through December | er 31 of the cost reporti | ng period (line | 0 | 24 |
| | 7 x line 19) | | | | |
| 5.00 | Swing-bed cost applicable to NF type services after December | 31 of the cost reporting | period (line 8 | 0 | 25 |
| (00 | x line 20) Total aving had aget (age instructions) | | | 0 | 24 |
| | Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost | (line 21 minus line 26) | | 0 636, 521 | |
| . 00 | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | | 030, 321 | 21 |
| 3. 00 | General inpatient routine service charges (excluding swing-be | ed and observation bed ch | arges) | 0 | 28 |
| 9.00 | Private room charges (excluding swing-bed charges) | | | 0 | |
| | Semi-private room charges (excluding swing-bed charges) | | | 0 | |
| | General inpatient routine service cost/charge ratio (line 27 | ÷line 28) | | 0.000000 | |
| | Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) | | | 0.00 | |
| | Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi | inus line 33)(see instruc | tions) | 0.00 0.00 | |
| | Average per diem private room cost differential (line 34 x li | | | 0.00 | |
| | Private room cost differential adjustment (line 3 x line 35) | | | 0.00 | |
| | General inpatient routine service cost net of swing-bed cost | and private room cost di | fferential (line | 636, 521 | |
| | 27 minus line 36) | | | | |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ | | | 0 100 70 | 1 20 |
| | Adjusted general inpatient routine service cost per diem (see | | | 2, 100. 73 | |
| 7. UU | Program general inpatient routine service cost (line 9 x line | | | 12, 604 0 | |
| | Medically necessary private room cost applicable to the Progr | | | | |

| | nancial Systems FA ION OF INPATIENT OPERATING COST | YETTE REGIONAL | Provider C | | Peri od: | eu of Form CMS- Worksheet D-1 | |
|-----------------|--|--------------------------|------------------------|-----------------------|----------------------------------|--------------------------------------|------------------|
| | | | Component | CCN: 15-S064 | From 10/01/2017 To 09/30/2018 | Date/Time Pre | |
| | | | Titl | e XIX | Subprovider - | 2/28/2019 1:0 Cost |)2 pm |
| | Cost Center Description | Total Inpatient Costl | Total npatient Days | | | Program Cost (col. 3 x col. 4) | |
| | | 1.00 | 2.00 | <u>col.2)</u> 3.00 | 4.00 | 5.00 | |
| | JRSERY (title V & XIX only) | 0 | C | 0. | 00 0 | 0 0 | 42. |
| | tensive Care Type Inpatient Hospital Units ITENSIVE CARE UNIT | 0 | 0 | 0. | 00 0 | | 43. |
| | DRONARY CARE UNIT | - | - | | | | 44. |
| | JRN INTENSIVE CARE UNIT | | | | | | 45. |
| | JRGI CAL I NTENSI VE CARE UNI T THER SPECI AL CARE (SPECI FY) | | | | | | 46. |
| . 00 [01 | Cost Center Description | | | | | 1.00 | 47. |
| 3. 00 Pr | rogram inpatient ancillary service cost (Wks | st. D-3, col. 3, | line 200) | | | 1.00 | 48. |
| 9. 00 To | otal Program inpatient costs (sum of lines 4 | | | ns) | | 14, 457 | 49. |
| | <u>SS THROUGH COST ADJUSTMENTS</u> ass through costs applicable to Program inpa | atient routine s | services (from | Wkst. D, su | n of Parts I and | 0 | 50. |
| | l) ass through costs applicable to Program inpa | ationt ancillary | , sarvicas (fr | om Wkst D | cum of Darts II | c | 51 |
| an | nd IV) | 5 | - 351 VI 68 (11 | UNI WRSL. D, S | Sum OF FAILS II | | |
| | otal Program excludable cost (sum of lines s | , | atod non rh | cician anact | notict and | | |
| me | otal Program inpatient operating cost exclue edical education costs (line 49 minus line 5 | | ateu, non-phy | sician anesti | | | 1 33 |
| | RGET AMOUNT AND LIMIT COMPUTATION | | | | | 0 | 54 |
| | arget amount per discharge | | | | | 0.00 | |
| | arget amount (line 54 x line 55) | | | | | 0 | 56 |
| | fference between adjusted inpatient operati | ng cost and tar | rget amount (I | ine 56 minus | line 53) | 0 | |
| | onus payment (see instructions) esser of lines 53/54 or 55 from the cost rep | porting period e | nding 1006 | ndated and c | ompounded by the | 0.00 | |
| | arket basket | boi ting period e | inding 1990, c | puated and c | shipourided by the | 0.00 | ' ³⁷ |
| | esser of lines 53/54 or 55 from prior year of | | | | | 0.00 | |
| | Fline 53/54 is less than the lower of lines | | | | | C | 61 |
| | nich operating costs (line 53) are less than nount (line 56), otherwise enter zero (see i | | s (TTHES 54 X | 60), OF 1% 0 | i the target | | |
| | elief payment (see instructions) | , | | | | 0 | 62 |
| | Iowable Inpatient cost plus incentive payme OGRAM INPATIENT ROUTINE SWING BED COST | ent (see instruc | ctions) | | | 0 | 63 |
| | edicare swing-bed SNF inpatient routine cost | ts through Decem | ber 31 of the | cost report | ng period (See | 0 | 64 |
| | nstructions)(title XVIII only) edicare swing-bed SNF inpatient routine cost | ts after Decembe | or 31 of the c | ost reportin | a period (See | 0 | 65 |
| | nstructions) (title XVIII only) | | | | g period (See | | / 03 |
| | otal Medicare swing-bed SNF inpatient routin AH (see instructions) | ne costs (line 6 | 64 plus line 6 | 5)(title XVI | ll only). For | 0 | 66 |
| | tle V or XIX swing-bed NF inpatient routine | e costs through | December 31 c | f the cost r | eporting period | C | 67 |
| | ine 12 x line 19) | anoto often De | annhar 21 of | the east rea | anting pariod | | |
| | tle V or XIX swing-bed NF inpatient routine ine 13 x line 20) | e costs arter De | ecember 31 OF | the cost rep | orting period | C | 68 |
| | ntal title V or XIX swing-bed NF inpatient n RT III - SKILLED NURSING FACILITY, OTHER NU | | | | | 0 | 69 |
| | killed nursing facility/other nursing facili | | | |) | | 70 |
| . 00 Ad | ljusted general inpatient routine service co | ost per diem (li | | | | | 71 |
| | rogram routine service cost (line 9 x line 1 | | (line 14 v li | no 25) | | | 72 |
| | edically necessary private room cost applica otal Program general inpatient routine servi | | | | | | 73 |
| 5. 00 Ca | apital-related cost allocated to inpatient i | | | | Part II, column | | 75 |
| | 5, line 45) er diem capital-related costs (line 75 ÷ lin | ne 2) | | | | | 76 |
| | rogram capital-related costs (line 9 x line | | | | | | 77 |
| | npatient routine service cost (line 74 minus ggregate charges to beneficiaries for excess | | ovider record | s) | | | 78 |
| 1 3 | otal Program routine service costs for compa | | | | nus line 79) | | 80 |
| .00 In | npatient routine service cost per diem limit | tation | | - | | | 81 |
| 1 | npatient routine service cost limitation (li | , | | | | | 82 |
| 1 | easonable inpatient routine service costs (s rogram inpatient ancillary services (see ins | | >) | | | | 83 |
| | ilization review - physician compensation | | ıs) | | | | 85 |
| 5. 00 <u>To</u> | otal Program inpatient operating costs (sum | of lines 83 thr | | | | | 86 |
| | RT IV - COMPUTATION OF OBSERVATION BED PASS | | | | | | 0.7 |
| 1 | otal observation bed days (see instructions) Hjusted general inpatient routine cost per d | | line 2) | | | 0.00 | |
| 1 | pservation bed cost (line 87 x line 88) (see | | | | | 0.00 | |

| Health Financial Systems Fi | AYETTE REGIONAL | HEALTH SYSTEM | | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|----------------|--------------|----------------------------|--------------------------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CO | | Period: From 10/01/2017 | Worksheet D-1 | |
| | | Component (| CCN: 15-S064 | To 09/30/2018 | Date/Time Pre 2/28/2019 1:0 | pared: 2 pm |
| | | Titl | e XIX | Subprovider - IPF | Cost | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observati on | |
| | | (from line 21) | column 2 | Observati on | Bed Pass | |
| | | | | Bed Cost (from | Through Cost | |
| | | | | line 89) | (col. 3 x col. | |
| | | | | | 4) (see | |
| | | | | | instructions) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital-related cost | 78, 192 | 636, 521 | 0. 12284 | 3 0 | 0 | 90.00 |
| 91.00 Nursing School cost | 0 | 636, 521 | 0. 00000 | 0 0 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 636, 521 | 0. 00000 | 0 0 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 636, 521 | 0.00000 | 0 0 | 0 | 93.00 |

| Health Financial Systems FA | YETTE REGIONAL HEALTH SYSTEM | | In Lie | u of Form CMS-2 | 2552-10 |
|---|------------------------------|----------------------|---|---|----------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der CCN | | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 Date/Time Pre 2/28/2019 1:0 | pared: |
| | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | F | Ratio of Cos | t Inpatient | Inpati ent | |
| | _ | To Charges | Charges | Program Costs (col. 1 x col. 2) | |
| | | 1.00 | 2.00 | 3.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | | | 1, 233, 649 | | 30.00 |
| 31. 00 03100 I NTENSI VE CARE UNI T | | | 488, 711 | | 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 | | | | | 43.00 |
| ANCI LLARY SERVICE COST CENTERS | | 0 40700 | 252 442 | 105 404 | 50.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | | 0. 49708 0. 20286 | | 125, 484 182, 311 | |
| 60. 00 06000 LABORATORY | | 0. 20280 | | 217, 347 | |
| 65. 00 06500 RESPIRATORY THERAPY | | 0. 20282 | | 163, 534 | |
| 66. 00 06600 PHYSICAL THERAPY | | 0. 28590 | | 46, 411 | |
| 69. 00 106900 ELECTROCARDI OLOGY | | 0. 00000 | | 40, 411 | |
| 69. 01 06901 CARDI AC REHAB | | 0. 93670 | | 0 | |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0. 63264 | | 170, 378 | |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS | | 0. 57821 | | 1, 934 | |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | | 0. 38338 | | 273, 441 | |
| OUTPATIENT SERVICE COST CENTERS | | 0.00000 | 710,200 | 270, 111 | /0.00 |
| 91. 00 09100 EMERGENCY | | 0. 21680 | 537, 159 | 116, 458 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 0. 88202 | | 0 | 1 |
| 93. 00 04050 CLINIC | | 1. 12084 | | 380 | |
| 93. 01 04950 BI C | | 0.01738 | | 0 | 1 |
| 93. 05 04954 PODI ATRY | | 0.00000 | | 0 | |
| OTHER REIMBURSABLE COST CENTERS | | 0100000 | | | 1 101 00 |
| 95. 00 09500 AMBULANCE SERVICES | | | | | 95.00 |
| 200.00 Total (sum of lines 50 through 94 and 9 | 6 through 98) | | 4, 380, 261 | 1, 297, 678 | 200.00 |
| 201.00 Less PBP Clinic Laboratory Services-Pro | | | 0 | | 201.00 |
| 202.00 Net charges (line 200 minus line 201) | | | 4, 380, 261 | | 202.00 |

| Health Financial Systems | FAYETTE REGIONAL HEALTH SYSTEM | Λ | In Lie | u of Form CMS-2 | 2552-10 |
|---|--------------------------------|--------------|----------------------------------|--------------------------------|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der C | CN: 15-0064 | Period: | Worksheet D-3 | |
| | Component | CCN: 15-SO64 | From 10/01/2017 To 09/30/2018 | Date/Time Pre 2/28/2019 1:0 | |
| | Titl | e XVIII | Subprovider - IPF | PPS | |
| Cost Center Description | | Ratio of Cos | | Inpati ent | |
| | | To Charges | Program | Program Costs | |
| | | | Charges | (col. 1 x col. | |
| | | 1.00 | 2.00 | <u>2)</u> 3. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | 1.00 | 2.00 | 5.00 | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | | | 0 | | 30.00 |
| 31.00 03100 I NTENSI VE CARE UNI T | | | 0 | | 31.00 |
| 40. 00 04000 SUBPROVIDER - IPF | | | 311, 816 | | 40.00 |
| 41.00 04100 SUBPROVIDER - IRF | | | 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. 4970 | | | 50.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | | 0. 2028 | | 30, 633 | |
| 60. 00 06000 LABORATORY | | 0. 2028 | | | |
| 65. 00 06500 RESPI RATORY THERAPY | | 0. 2859 | | | |
| 66. 00 06600 PHYSI CAL THERAPY | | 0. 74498 | | 19, 855 | |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0.0000 | | 0 | 69.00 |
| 69. 01 06901 CARDI AC REHAB | | 0. 93670 | | 0 | 69.01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN | S | 0. 6326 | | 3, 149 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | | 0. 5782 | | 0 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | | 0. 3833 | 82 491, 745 | 188, 526 | 73.00 |
| 0UTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY | | 0.2168 | 03 106, 481 | 23, 085 | 91.00 |
| 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR | N | 0. 2168 | | | 91.00 |
| 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PAR 93. 00 04050 CLINIC |) | 1. 1208 | | 0 | 92.00 |
| 93. 01 04950 BLC | | 0. 0173 | | | 93.00 |
| 93. 05 04954 PODI ATRY | | 0.0000 | | | 93.01 |
| OTHER REIMBURSABLE COST CENTERS | | 0.0000 | 0 | 0 | 73.03 |
| 95. 00 09500 AMBULANCE SERVICES | | | | | 95.00 |
| 200.00 Total (sum of lines 50 through 94 a | nd 96 through 98) | | 1, 073, 407 | 325, 108 | |
| 201.00 Less PBP Clinic Laboratory Services | | | 0 | 323, 100 | 201.00 |
| 202.00 Net charges (line 200 minus line 20 | | | 1, 073, 407 | | 202.00 |

| Health Financial Systems | FAYETTE REGIONAL HEALTH SYSTEM | 1 | In Lie | u of Form CMS- | 2552-10 |
|--|--------------------------------|--------------|----------------------------|--------------------------------|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der C | CN: 15-0064 | Period: From 10/01/2017 | Worksheet D-3 | |
| | | | To 09/30/2018 | Date/Time Pre 2/28/2019 1:0 | |
| | | e XIX | Hospi tal | Cost | |
| Cost Center Description | | Ratio of Cos | | Inpati ent | |
| | | To Charges | Program | Program Costs | |
| | | | Charges | (col. 1 x col. | |
| | | 1.00 | | 2) | |
| INDATIENT DOUTINE CEDVICE COST CENTEDS | | 1.00 | 2.00 | 3.00 | |
| 30. 00 03000 ADULTS & PEDIATRICS | | | 60, 989 | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | | | 9, 728 | | 31.00 |
| 40. 00 04000 SUBPROVIDER - IPF | | | 9, 720 | | 40.00 |
| 41. 00 04100 SUBPROVI DER - I RF | | | 0 | | 40.00 |
| 42. 00 04200 SUBPROVI DER | | | 0 | | 41.00 |
| 43. 00 04300 NURSERY | | | 20, 258 | | 43.00 |
| ANCI LLARY SERVICE COST CENTERS | | 1 | 20, 200 | | +5.00 |
| 50. 00 05000 OPERATING ROOM | | 0.4970 | 81 60, 397 | 30, 022 | 50.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | | 0. 2028 | | | |
| 60. 00 06000 LABORATORY | | 0. 2028 | | | |
| 65. 00 06500 RESPI RATORY THERAPY | | 0. 2859 | | | |
| 66. 00 06600 PHYSI CAL THERAPY | | 0.74498 | | 0 | 66.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0.0000 | 0 00 | 0 | 69.00 |
| 69. 01 06901 CARDI AC REHAB | | 0. 93670 | 0 0 | 0 | 69.01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0. 6326 | 41 60, 242 | 38, 112 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | | 0. 5782 | 14 0 | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | | 0. 3833 | 82 132, 250 | 50, 702 | 73.00 |
| OUTPATIENT SERVICE COST CENTERS | | 1 | | | |
| 91. 00 09100 EMERGENCY | | 0. 2168 | | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 0. 88202 | | 0 | 92.00 |
| 93. 00 04050 CLI NI C | | 1. 1172 | | 747 | 93.00 |
| 93. 01 04950 BIC | | 0.0173 | | 0 | |
| 93. 05 04954 PODI ATRY | | 0.0000 | 0 00 | 0 | 93.05 |
| OTHER REIMBURSABLE COST CENTERS | | 1 | | | |
| 95. 00 09500 AMBULANCE SERVICES | | | (00.745 | | 95.00 |
| 200.00 Total (sum of lines 50 through 94 and | | | 688, 715 | 211, 813 | |
| 201.00 Less PBP Clinic Laboratory Services-F | | | 0 | | 201.00 |
| 202.00 Net charges (line 200 minus line 201) | 1 | I | 688, 715 | | 202.00 |

| INPATI ENT ROUTI NE SERVICE COST CENTERS 0 | Health Financial Systems | FAYETTE REGIONAL HEALTH SYSTEM | Λ | In Lie | eu of Form CMS- | 2552-10 |
|--|--|--------------------------------|--------------|-----------|--------------------------------|---------|
| Component CCN: 15-S064 To 09/30/2018 Date/Time Preview Title XIX Subprovider - IPF Cost Cost Cost Center Description Ratio of Cost Inpatient To Charges Inpatient Program Charges Inpatient Program Cost Inpatient Inpatient Inpati | INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider C | CN: 15-0064 | | Worksheet D-3 | |
| Interview Title XIX Subprovider - IPF Cost Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpa | | Component | CCN: 15-SO64 | | Date/Time Pre 2/28/2019 1:0 | |
| Impart ENT ROUTINE SERVICE COST CENTERS To Charges Program (Charges (col. 1 x col. 2)) 30.00 03000 ADULTS & PEDIATRICS 0 3.00 31.00 03000 ADULTS & PEDIATRICS 0 0 40.00 Q4000 SUBPROVI DER - 1 PF 0 0 41.00 04100 SUBPROVI DER - 1 RF 0 0 42.00 04300 NURSERY 0 0 ANCILLARY SERVICE COST CENTERS 0 0 0 50.00 05400 RADI OLGY DI AGNOSTI C 0.202866 726 147 60.00 06600 PHYSI CAL THERAPY 0.202867 1.282 260 65.00 06500 RESPI RATORY THERAPY 0.202867 1.282 260 66.00 06600 PHYSI CAL THERAPY 0.202861 0 0 0 0 0 0 0 0 0 0 0 0 </td <td></td> <td>Tit</td> <td>e XIX</td> <td></td> <td>Cost</td> <td></td> | | Tit | e XIX | | Cost | |
| INPATIENT ROUTINE SERVICE COST CENTERS Control 1 x coll Control 2 y 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 0 31.00 03100 INTENSIVE CARE UNIT 0 40.00 04000 SUBPROVIDER - IPF 962 41.00 04010 SUBPROVIDER - IFF 962 42.00 04200 SUBPROVIDER 0 43.00 03000 NURSERY 0 ANCILLARY SERVICE COST CENTERS 0 0 50.00 05000 0PERATING ROOM 0.497081 0 ANCILLARY SERVICE COST CENTERS 0 0 0 60.00 06000 LABORATORY 0.202868 726 147 60.00 06000 PENATING ROOM 0.497081 0 0 61.00 06000 PHYSICAL THERAPY 0.202867 1.282 266 65.00 06500 RESPI RATORY THERAPY 0.285961 0 0 69.01 06901 CARDIAC REHAB 0.936701 0 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATIENTS 0.632641 <td< td=""><td>Cost Center Description</td><td></td><td></td><td></td><td></td><td></td></td<> | Cost Center Description | | | | | |
| INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 2.00 3.00 30. 00 03000 ADULTS & PEDI ATRI CS 0 | | | To Charges | | | |
| INPATI ENT ROUTI NE SERVI CE COST CENTERS 0.00 03000 (ADULTS & PEDI ATRI CS 0 31.00 03100 I INTENSI VE CARE UNI T 0 40.00 04000 SUBPROVI DER - I PF 0 41.00 04100 SUBPROVI DER - I RF 0 42.00 04200 SUBPROVI DER 0 43.00 04300 NURSERY 0 ANCI LLARY SERVI CE COST CENTERS 0 50.00 05000 [PERATI NG ROOM 0.497081 0 60.00 06000 LLABORATORY 0.202862 7.26 74.00 06000 CABORATORY 0.202863 7.26 74.00 06000 LABORATORY 0.202827 1.282 75.00 05000 [PERSPI RATORY THERAPY 0.202827 1.282 76.00 06000 [LABORATORY 0.202827 1.282 71.00 06000 [LABORATORY 0.285961 0 0 72.00 05000 [LABORATORY 0.333382 2.298 831 71.00 05900 [LAUETREADED TO PATI ENTS 0.578214 0 0 70.00 07300 [DRUGS CHAR | | | | Charges | | |
| INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 31.00 03000 INTENSIVE CARE UNIT 0 40.00 04000 SUBPROVIDER - 1PF 962 41.00 04100 SUBPROVIDER - 1FF 0 42.00 04200 SUBPROVIDER 0 43.00 04300 NURSERY 0 ANCILLARY SERVICE COST CENTERS 0 0 40.00 05400 RADIOLOGY - DIAGNOSTIC 0.202868 726 50.00 05400 RATORY HERAPY 0.202867 1, 282 260 65.00 06500 RESPIRATORY HERAPY 0.202867 1, 282 260 65.00 06500 RESPIRATORY HERAPY 0.285961 0 0 69.00 06600 PHYSI CAL THERAPY 0.33620 0.936701 0 0 69.00 06901 CARDIA C REHAB 0.33822 2.948 881 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.38382 2. | | | 1 00 | 2 00 | | |
| 30.00 O3000 ADULTS & PEDIATRICS 0 31.00 O3100 INTENSIVE CARE UNIT 0 40.00 OVA000 SUBPROVI DER - IPF 962 41.00 O4100 SUBPROVI DER - IRF 0 42.00 O4200 SUBPROVI DER - IRF 0 43.00 O4300 NUSESRY 0 ANCILLARY SERVICE COST CENTERS 0 0 50.00 O5000 OPERATING ROOM 0.497081 0 0 40.00 AUBORATORY 0.202868 72.6 147 60.00 OPERATING ROOM 0.202827 1, 282 260 61.00 O6500 RESPI RATORY THERAPY 0.202827 1, 282 260 62.00 06500 RESPI RATORY THERAPY 0.202827 1, 282 260 63.00 06500 RESPI RATORY THERAPY 0.202827 1, 282 260 64.00 O6900 ELECTROCARDI OLOGY 0.000000 0 0 64.00 O6900 ELECTROCARDI OLOGY 0.000000 0 0 71.00 MEDI CAL SUPPLIES CHAREE | INPATIENT ROUTINE SERVICE COST CENTERS | | 1.00 | 2.00 | 3.00 | |
| 40.00 SUBPROVI DER - 1 PF 962 41.00 O4100 SUBPROVI DER - 1 RF 0 42.00 O4200 SUBPROVI DER 0 43.00 O4300 NURSERY 0 ANCI LLARY SERVI CE COST CENTERS 0 0 50.00 O5000 OPERATI NG ROOM 0.497081 0 64.00 O6400 RABIOLOGY-DI AGNOSTI C 0.202868 726 65.00 O6500 RESPI RATORY THERAPY 0.202827 1,282 260 65.00 O6600 PHYSI CAL THERAPY 0.285961 0 0 0 66.00 06600 PHYSI CAL THERAPY 0.285961 0 0 0 0 67.00 06900 ELECTROCARDI OLOGY 0.203627 1 0 < | | | | 0 | | 30.00 |
| 41.00 04100 SUBPROVI DER - I RF 0 42.00 04200 SUBPROVI DER 0 43.00 04300 NURSERY 0 ANCI LLARY SERVICE COST CENTERS 0 0 50.00 05000 OPERATI NG ROOM 0.497081 0 64.00 0.4000 AURSERY 0 0.202868 72.6 50.00 05000 OPERATI NG ROOM 0.202827 1, 282 2600 65.00 06500 RESPI RATORY THERAPY 0.285961 0 0 0 66.00 06600 DHYSI CAL THERAPY 0.285961 0 <td< td=""><td>31.00 03100 INTENSIVE CARE UNIT</td><td></td><td></td><td>0</td><td></td><td>31.00</td></td<> | 31.00 03100 INTENSIVE CARE UNIT | | | 0 | | 31.00 |
| 42.00 04200 SUBPROVI DER 0 43.00 04300 NURSERY 0 ANCI LLARY SERVICE COST CENTERS 0 ANCI LLARY SERVICE COST CENTERS 0 50.00 05000 OPERATI NG ROM 0.497081 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.202868 726 147 60.00 06600 LABORATORY 0.202827 1,282 266 65.00 06500 RESPI RATORY THERAPY 0.285961 0 | 40. 00 04000 SUBPROVIDER - IPF | | | 962 | | 40.00 |
| 43.00 Od300 NURSERY 0 ANCILLARY SERVICE COST CENTERS | 41. 00 04100 SUBPROVIDER - IRF | | | 0 | | 41.00 |
| ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 0.497081 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.202868 726 147 60. 00 06000 LABORATORY 0.202827 1,282 260 65. 00 06500 RESPI RATORY THERAPY 0.285961 0 0 0 66. 00 06900 LECTROCARDI OLOGY 0.744985 547 408 69. 01 06901 CARDI AC REHAB 0.00000 0 0 69. 01 06901 CARDI AC REHAB 0.936701 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.578214 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.383382 2,298 881 0UTPATIENT SERVICE COST CENTERS 0.9100 EMEGENCY 0 0 0 91. 00 09100 EMEGENCY 0.216803 619 134 92. 00 092200 DBSERVATI ON BEDS (NON-DI STI NCT PART) | 42. 00 04200 SUBPROVI DER | | | 0 | | 42.00 |
| 50.00 05000 0PERATI NG ROOM 0.497081 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.202868 726 147 60.00 06000 LABORATORY 0.202827 1,282 260 65.00 06500 RESPI RATORY THERAPY 0.285961 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0.744985 547 408 69.00 06901 CARDI AC REHAB 0.936701 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.632641 22 14 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0.578214 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.383382 2,298 881 0UTPATI ENT SERVI CE COST CENTERS 0 0.216803 619 134 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0.882025 0 0 93.01 04950 BI C 0.017381 0 0 0 0 93.05 04954 PODI ATRY 0.000000 | | | | 0 | | 43.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.202868 726 147 60.00 06000 LABORATORY 0.202827 1,282 260 65.00 06500 RESPI RATORY THERAPY 0.285961 0 0 0 66.00 06600 PHYSI CAL THERAPY 0.744985 547 408 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 69.01 06901 CARDI AC REHAB 0.936701 0 0 0 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.632641 22 14 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.578214 0 0 0 001TPATI ENT SERVI CE COST CENTERS 0 91.00 09100 EMERGENCY 0.216803 619 134 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.882025 0 0 0 0 93.01 04950 BI C 0.017381 0 0 0 0 0 0 0 | ANCI LLARY SERVI CE COST CENTERS | | | | | |
| 60.00 06000 LABORATORY 0.202827 1,282 2600 65.00 06500 RESPI RATORY THERAPY 0.285961 0 0 66.00 06600 PHYSI CAL THERAPY 0.744985 547 408 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 69.01 06901 CARDI AC REHAB 0.936701 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.632641 22 14 72.00 07200 IMPL | 50. 00 05000 OPERATI NG ROOM | | 0. 49708 | 31 0 | 0 | 50.00 |
| 65.00 06500 RESPI RATORY THERAPY 0.285961 0 0 66.00 06600 PHYSI CAL THERAPY 0.744985 547 408 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69.01 06901 CARDI AC REHAB 0.936701 0 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.632641 22 14 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.578214 0 0 0.017300 DRUGS CHARGED TO PATI ENTS 0.383382 2,298 881 0UTPATI ENT SERVICE COST CENTERS 0.216803 619 134 91.00 09100 EMERGENCY 0.882025 0 0 91.00 09100 EMERGENCY 0.017381 0 0 93.01 04950 BI C 0.017381 0 0 0 93.05 04954 POI ATRY 0.000000 0 0 0 93.05 04950 BI C 0.000000 0 0 0 93.05 0 | | | | | | |
| 66.00 06600 PHYSI CAL THERAPY 0.744985 547 408 69.00 06900 ELECTROCARDI OLOGY 0.000000 | | | | | 260 | |
| 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 00 69.01 06901 CARDI AC REHAB 0.936701 0 00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.632641 22 14 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.578214 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.383382 2,298 881 0UTPATI ENT SERVICE COST CENTERS 0.216803 619 134 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0.882025 0 0 93.00 04950 EL 0.017381 0 0 0 93.01 04950 BL 0.000000 0 0 0 01HER REI MBURSABLE COST CENTERS 0 0.000000 0 0 0 | | | | | | |
| 69.01 06901 CARDI AC REHAB 0.936701 0 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.632641 22 14 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.578214 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.383382 2,298 881 OUTPATI ENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0.216803 619 134 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.882025 0 0 0 93.01 04050 CLI NI C 1.117212 8 9 9 0 0 93.05 04954 POLI ATRY 0.00000 0 0 0 0 0 95.00 09500 AMBULANCE SERVICES 0 0500 MBULANCE SERVICES 0 0 0 | | | | | 408 | |
| 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.632641 22 14 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.578214 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.383382 2,298 881 OUTPATI ENT SERVICE COST CENTERS 91.00 O9200 DSERVATI ON BEDS (NON-DI STI NCT PART) 0.882025 0 0 93.00 04050 CLI NI C 1.117212 8 9 93.01 04950 BI C 0.000000 0 0 0THER REI MBURSABLE COST CENTERS 0.017381 0 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 | | | | | 0 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.578214 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.383382 2,298 881 OUTPATIENT SERVICE COST CENTERS 0.216803 619 134 91.00 09200 0BSERVATION BEDS (NON-DI STINCT PART) 0.882025 0 0 93.01 04950 BIC 0.117212 8 9 93.01 04950 BIC 0.000000 0 0 0THER REIMBURSABLE COST CENTERS 0 0 0 0 95.00 09500 AMBULANCE SERVICES 0 0 0 | | | | | 0 | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS 0.383382 2,298 881 OUTPATIENT SERVICE COST CENTERS 0.216803 619 134 91.00 09100 EMERGENCY 0.216803 619 134 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0.882025 0 0 93.01 04950 GL I NI C 1.117212 8 9 93.01 04950 BI C 0.000000 0 0 93.05 04954 PODI ATRY 0.000000 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 95.00 09500 AMBULANCE SERVICES 0 0 0 | | TS | | | 14 | |
| OUTPATI ENT_SERVICE_COST_CENTERS 91.00 09100 EMERGENCY 0.216803 619 134 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0.882025 0 0 93.00 04050 CLI NI C 1.117212 8 9 93.01 04950 BI C 0.017381 0 0 93.05 04954 PODI ATRY 0.000000 0 0 0THER_REIMBURSABLE_COST_CENTERS 95.00 09500 AMBULANCE_SERVICES 0 0 | | | | | 0 | |
| 91.00 09100 EMERGENCY 0.216803 619 134 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.882025 0 0 93.00 04050 CLINIC 1.117212 8 9 93.01 04950 BIC 0.017381 0 0 93.05 04954 PODIATRY 0.000000 0 0 0THER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 | | | 0. 38338 | 32 2, 298 | 881 | 73.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.882025 0 0 93.00 04050 CLINIC 1.117212 8 9 93.01 04950 BIC 0.017381 0 00 93.05 04954 PODIATRY 0.000000 0 0 0THER REI MBURSABLE COST CENTERS 9 0 0 0 | | | 0.01/0 | | 404 | 01 00 |
| 93.00 04050 CLINIC 1.117212 8 9 93.01 04950 BIC 0.017381 0 00 93.05 04954 PODIATRY 0.000000 0 00 0THER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 | | | | | | |
| 93. 01 04950 BI C 0.017381 0 00 93. 05 04954 PODI ATRY 0.000000 0 0 0 93. 05 04954 PODI ATRY 0.000000 0 0 0 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 | | 1) | | | | |
| 93.05 04954 PODI ATRY 0.00000 0 C 0THER REI MBURSABLE COST CENTERS 0 0 C 95.00 09500 AMBULANCE SERVICES 0 0 C | | | | | | |
| OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES | | | | | | 93.01 |
| 95. 00 09500 AMBULANCE SERVICES | | | 0.0000 | | 0 | 93.05 |
| | | | | | | 95.00 |
| | | and 96 through 98) | | 5, 502 | 1 853 | 200.00 |
| 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 | | | | 0, 302 | 1,000 | 201.00 |
| 202.00 Net charges (line 200 minus line 201) 5,502 | | | | 5 502 | | 202.00 |

| Heal th Financi | ial Systems | FAYETTE REGIONAL HEALTH SYSTEM | Л | In Lie | u of Form CMS-2 | 2552-10 |
|-----------------|--------------------------------------|--------------------------------|--------------|----------------------------------|-----------------|---------|
| INPATIENT ANC | ILLARY SERVICE COST APPORTIONMENT | Provider C | | Period: | Worksheet D-3 | |
| | | Component | CCN: 15-U064 | From 10/01/2017 To 09/30/2018 | Date/Time Pre | narodi |
| | | component | CCN. 15-0004 | 10 09/30/2016 | 2/28/2019 1:0 | |
| | | Ti tl | | Swing Beds - SNF | | |
| C | Cost Center Description | | Ratio of Cos | | Inpati ent | |
| | | | To Charges | | Program Costs | |
| | | | | Charges | (col. 1 x col. | |
| | | | | | 2) | |
| | | | 1.00 | 2.00 | 3.00 | |
| | ENT ROUTINE SERVICE COST CENTERS | | 1 | 0 | | 30.00 |
| | NTENSIVE CARE UNIT | | | 0 | | 30.00 |
| | SUBPROVIDER - IPF | | | 0 | | 40.00 |
| | SUBPROVIDER - IRF | | | 0 | | 40.00 |
| | SUBPROVIDER | | | 0 | | 41.00 |
| 43.00 04300 N | | | | 0 | | 42.00 |
| | ARY SERVICE COST CENTERS | | | 0 | | 45.00 |
| | DERATING ROOM | | 0.0000 | 0 0 | 0 | 50.00 |
| | RADI OLOGY-DI AGNOSTI C | | 0.00000 | | | • |
| | ABORATORY | | 0.00000 | | 0 | |
| 65.00 06500 R | RESPI RATORY THERAPY | | 0.00000 | | 0 | 65.00 |
| 66.00 06600 P | PHYSI CAL THERAPY | | 0.00000 | 0 0 | 0 | 66.00 |
| 69.00 06900 E | LECTROCARDI OLOGY | | 0.00000 | 0 0 | 0 | 69.00 |
| 69.01 06901 C | CARDI AC REHAB | | 0.00000 | 0 0 | 0 | 69.01 |
| 71.00 07100 M | IEDICAL SUPPLIES CHARGED TO PATIENTS | 5 | 0.00000 | 0 0 | 0 | 71.00 |
| 72.00 07200 1 | MPL. DEV. CHARGED TO PATIENTS | | 0.00000 | 0 0 | 0 | 72.00 |
| 73.00 07300 D | RUGS CHARGED TO PATIENTS | | 0.00000 | 0 0 | 0 | 73.00 |
| | ENT SERVICE COST CENTERS | | | _ | | |
| | MERGENCY | | 0.00000 | | | |
| | DBSERVATION BEDS (NON-DISTINCT PART) | | 0.00000 | | 0 | |
| 93.00 04050 C | | | 0.00000 | | 0 | |
| 93.01 04950 B | | | 0.00000 | | 0 | |
| 93.05 04954 P | | | 0.00000 | 0 0 | 0 | 93.05 |
| | REIMBURSABLE COST CENTERS | | | | | |
| | MBULANCE SERVICES | | | | | 95.00 |
| | otal (sum of lines 50 through 94 ar | | | 0 | | 200.00 |
| | ess PBP Clinic Laboratory Services- | | | 0 | | 201.00 |
| 202.00 N | let charges (line 200 minus line 201 |) | I | 0 | | 202.00 |

| ALCUL | ATION OF REIMBURSEMENT SETTLEMENT | EALTH SYSTEM Provider CCN: 15-0064 | In Lie Period: From 10/01/2017 To 09/30/2018 | Worksheet E Part A Date/Time Pre 2/28/2019 1:0 | pared: 2 pm |
|----------------|---|---------------------------------------|---|---|----------------|
| | | Title XVIII | Hospi tal | PPS | - 12.12 |
| | | | | 1.00 | |
| | PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS | | | | |
| 00 | DRG Amounts Other than Outlier Payments | | , | 0 | 1.0 |
| 01 | DRG amounts other than outlier payments for discharges occurr instructions) | ing prior to Uctober i | see | 0 | 1.0 |
| 02 | DRG amounts other than outlier payments for discharges occurr | ing on or after October | 1 (see | 1, 630, 424 | 1.0 |
| 00 | instructions) | | | 0 | 1 1 0 |
| 03 | DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions) | or discharges occurring | prior to uctober | 0 | 1.0 |
| 04 | DRG for federal specific operating payment for Model 4 BPCI f | or discharges occurring | on or after | 0 | 1.0 |
| 00 | October 1 (see instructions) | | | | 2 |
| 00 01 | Outlier payments for discharges. (see instructions) Outlier reconciliation amount | | | 25, 767 0 | 2.0 |
| 02 | Outlier payment for discharges for Model 4 BPCI (see instruct | i ons) | | 0 | 2.0 |
| 00 | Managed Care Simulated Payments | | | 0 | 3.0 |
| 00 | Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment | rting period (see instru | uctions) | 43.65 | 4.0 |
| 00 | FTE count for allopathic and osteopathic programs for the mos | t recent cost reporting | period ending on | 0.00 | 5.0 |
| | or before 12/31/1996. (see instructions) | 5 | 1 | | |
| 00 | FTE count for allopathic and osteopathic programs that meet t | he criteria for an add-o | on to the cap for | 0.00 | 6. (|
| 00 | new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified | under 42 CFR §412 105(f) | (1)(iv)(B)(1) | 0.00 | 7.0 |
| 01 | ACA § 5503 reduction amount to the IME cap as specified under | | | 0.00 | 7.0 |
| | cost report straddles July 1, 2011 then see instructions. | | | | |
| 00 | Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. | | | 0.00 | 8. |
| | 1998), and 67 FR 50069 (August 1, 2002). | 79(C)(Z)(TV), 04 TK 203 | +0 (Way 12, | | |
| 01 | The amount of increase if the hospital was awarded FTE cap sl | ots under § 5503 of the | ACA. If the cost | 0.00 | 8. |
| 0.2 | report straddles July 1, 2011, see instructions. | ata from a alacad taaabi | na haanital | 0.00 | |
| 02 | The amount of increase if the hospital was awarded FTE cap sl under § 5506 of ACA. (see instructions) | ots from a crosed teach | ng nospi tai | 0.00 | 8. |
| 00 | Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin | es (8, 8,01 and 8,02) | (see | 0.00 | 9. |
| | instructions) | | | 0.00 | 10 |
| D. 00 1. 00 | FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs. | ent year from your recor | as | 0.00 | |
| 2.00 | Current year allowable FTE (see instructions) | | | 0.00 | |
| 3. 00 | Total allowable FTE count for the prior year. | | | 0.00 | |
| 4. 00 | Total allowable FTE count for the penultimate year if that ye | ar ended on or after Sep | otember 30, 1997, | 0.00 | 14. |
| 5. 00 | otherwise enter zero. Sum of lines 12 through 14 divided by 3. | | | 0.00 | 15 |
| | Adjustment for residents in initial years of the program | | | 0.00 | |
| | Adjustment for residents displaced by program or hospital clo | sure | | 0.00 | |
| | Adjusted rolling average FTE count | ` | | 0.00 | |
| 9.00 0.00 | Current year resident to bed ratio (line 18 divided by line 4 Prior year resident to bed ratio (see instructions) | | | 0. 000000 0. 000000 | |
| | Enter the lesser of lines 19 or 20 (see instructions) | | | 0. 000000 | |
| | IME payment adjustment (see instructions) | | | 0 | |
| 2. 01 | IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42. | 2 of the MMA | | 0 | 22. |
| 3. 00 | Number of additional allopathic and osteopathic IME FTE resid | | CFR 412, 105 | 0.00 | 23. |
| | (f)(1)(iv)(C). | | | | |
| | IME FTE Resident Count Over Cap (see instructions) | | 24 (| 0.00 | |
| 5.00 | If the amount on line 24 is greater than -O-, then enter the instructions) | Tower of Tine 23 of Tine | e 24 (See | 0.00 | 25. |
| 5.00 | Resident to bed ratio (divide line 25 by line 4) | | | 0.000000 | 26. |
| 7.00 | IME payments adjustment factor. (see instructions) | | | 0.000000 | |
| | IME add-on adjustment amount (see instructions) |) | | 0 | 28. |
| 3. 01 9. 00 | IME add-on adjustment amount - Managed Care (see instructions Total IME payment (sum of lines 22 and 28) |) | | 0 | 28. 29. |
| 9. 00 9. 01 | Total IME payment - Managed Care (sum of lines 22.01 and 28.0 | 1) | | 0 | 29. |
| | Disproportionate Share Adjustment | | | | 1 |
| | Percentage of SSI recipient patient days to Medicare Part A p | atient days (see instruc | ctions) | 6.34 | |
| | Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31 | | | 28. 41 34. 75 | |
| 2.00 3.00 | Allowable disproportionate share percentage (see instructions |) | | 12.00 | |
| 1 00 | Disproportionate share adjustment (see instructions) | | | 48, 913 | |

| LCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0064 | Peri od: | Worksheet E | |
|---|---|---------------------------|----------------------------------|----------------------------------|----------------------------------|
| | | | From 10/01/2017 To 09/30/2018 | | |
| | | Title XVIII | Hospi tal | 2/28/2019 1:03 PPS | z pili |
| | | | Prior to 10/1 | | |
| | | | 1.00 | 2.00 | |
| | Uncompensated Care Adjustment | | | / 7// /05 1// | 1 25 |
| 5. 00 5. 01 | Total uncompensated care amount (see instructions) Factor 3 (see instructions) | | 0. 00000000 | 6, 766, 695, 164 0. 000074809 | |
| 5. 02 | Hospital uncompensated care payment (If line 34 is zero, ente | er zero on this line) (se | | 506, 210 | |
| . 02 | instructions) | | | 500, 210 | 00. |
| 6. 03 | Pro rata share of the hospital uncompensated care payment amo | ount (see instructions) | 0 | 506, 210 | 35. |
| . 00 | Total uncompensated care (sum of columns 1 and 2 on line 35.0 | | 506, 210 | | 36. |
|). 00 | Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges on Worksheet S-3, Part I excluding | | ugh 46) 0 | | 40. |
| . 00 | 652, 682, 683, 684 and 685 (see instructions) | ul schal ges 101 MS-DRGS | 0 | | 40. |
| | | | Before 1/1 | On/After 1/1 | |
| | | | 1.00 | 1.01 | |
| . 00 | Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6 | 683, 684 an 685. (see | 0 | 0 | 41. |
| . 01 | instructions) Total ESRD Medicare covered and paid discharges excluding MS- | | 4 0 | 0 | 41. |
| 01 | an 685. (see instructions) | -DRGS 032, 082, 083, 084 | + 0 | 0 | 41 |
| . 00 | Divide line 41 by line 40 (if less than 10%, you do not quali | fy for adjustment) | 0.00 | | 42 |
| . 00 | Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68 | 32, 683, 684 an 685. (see | e 0 | | 43 |
| ~ ~ | instructions) | | | | |
| . 00 | Ratio of average length of stay to one week (line 43 divided days) | by line 41 divided by / | 0.000000 | | 44 |
| . 00 | Average weekly cost for dialysis treatments (see instructions | 5) | 0.00 | 0.00 | 45 |
| 00 | Total additional payment (line 45 times line 44 times line 41 | 1.01) | 0 | | 46 |
| 00 | Subtotal (see instructions) | | 2, 211, 314 | | 47 |
| . 00 | Hospital specific payments (to be completed by SCH and MDH, s | small rural hospitals | 0 | | 48 |
| | only. (see instructions) | | | Amount | |
| | | | | 1.00 | |
| . 00 | Total payment for inpatient operating costs (see instructions | 5) | | 2, 211, 314 | |
| 00 | Payment for inpatient program capital (from Wkst. L, Pt. I ar | |) | 131, 478 | |
| 00 | Exception payment for inpatient program capital (Wkst. L, Pt. | | | 0 | 51 |
| 00 | Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment | ne 49 see instructions). | | 0 | 52 53 |
| 00 | Special add-on payments for new technologies | | | 0 | 54 |
| . 01 | Islet isolation add-on payment | | | 0 | 54 |
| . 00 | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 | 69) | | 0 | 55 |
| . 00 | Cost of physicians' services in a teaching hospital (see intr | ructions) | | 0 | 56 |
| . 00 | Routine service other pass through costs (from Wkst. D, Pt. I | | through 35). | 0 | 57 |
| . 00 | Ancillary service other pass through costs from Wkst. D, Pt. | IV, col. 11 line 200) | | 0 | 58 |
| . 00 . 00 | Total (sum of amounts on lines 49 through 58) | | | 2, 342, 792 0 | 59 60 |
| . 00 | Primary payer payments Total amount payable for program beneficiaries (line 59 minus | s line 60) | | 2, 342, 792 | |
| . 00 | Deductibles billed to program beneficiaries | s The boy | | 2, 342, 772 | |
| 00 | Coinsurance billed to program beneficiaries | | | 0 | |
| . 00 | Allowable bad debts (see instructions) | | | 73, 485 | |
| ~~ | Adjusted reimbursable bad debts (see instructions) | | | 47, 765 | |
| . 00 | Allowable bad debts for dual eligible beneficiaries (see inst | tructions) | | 73, 485 | |
| . 00 | Subtotal (line 61 plus line 65 minus lines 62 and 63) | | | 2, 094, 905 | |
| 00 00 | Constitute and should form an an feature of feature of the set of | | , | 0 | 68 69 |
| 00 00 00 | Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) | | 13) | 0 | 70 |
| 00 00 00 00 | Outlier payments reconciliation (sum of lines 93, 95 and 96). | | | | 70 |
| . 00 . 00 . 00 . 00 . 00 | Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | instructions) | 0 | |
| . 00 . 00 . 00 . 00 . 00 . 50 | Outlier payments reconciliation (sum of lines 93, 95 and 96). | | instructions) | 0 | 70 |
| . 00 . 00 . 00 . 00 . 00 . 50 . 87 . 88 | Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) | tration) adjustment (see | instructions) | | 70 |
| . 00 . 00 . 00 . 00 . 00 . 50 . 87 . 88 . 89 | Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst | tration) adjustment (see | instructions) | 0 0 | 70 70 |
| . 00 . 00 . 00 . 00 . 00 . 50 . 87 . 88 . 89 . 90 | Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) | tration) adjustment (see | instructions) | 0 0 | 70 70 70 |
| . 00 . 00 . 00 . 00 . 50 . 87 . 88 . 89 . 90 . 91 | Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) | tration) adjustment (see | instructions) | 0 0 0 | 70 70 70 70 |
| . 00 . 00 . 00 . 00 . 50 . 50 . 87 . 88 . 89 . 90 . 91 . 92 | Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions) | tration) adjustment (see | instructions) | 0 0 0 0 | 70 70 70 70 70 70 |
| 5. 00 5. 00 7. 00 8. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 87 9. 88 9. 89 9. 90 9. 91 9. 92 9. 93 9. 94 | Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) | tration) adjustment (see | instructions) | 0 0 0 | |

| LCULATION OF REIMBURSEMENT SETTLEMENT Pr | rovider CC | N: 15-0064 | Period: From 10/01/2017 | Worksheet E Part A | |
|--|--------------------------------------|---------------|----------------------------|-----------------------|--|
| | | | To 09/30/2018 | | pare 2 pm |
| | Title | XVIII | Hospi tal | PPS | |
| | | FFY | (уууу) | Amount | |
| | | | 0 | 1.00 | |
| .96 Low volume adjustment for federal fiscal year (yyyy) (Enter in c | olumn O | | 0 | 0 | 70 |
| the corresponding federal year for the period prior to 10/1) .97 Low volume adjustment for federal fiscal year (yyyy) (Enter in c | | | 0 | 0 | 70 |
| the corresponding federal year for the period ending on or after .98 Low Volume Payment-3 | 1071) | | | 0 | |
| .99 HAC adjustment amount (see instructions) | | | | 0 | |
| .00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 | & /0) | | | 2, 107, 680 | |
| .01 Sequestration adjustment (see instructions) | | | | 42, 154 | |
| .02 Demonstration payment adjustment amount after sequestration | | | | 0 | 71 |
| .00 Interim payments | | | | 1, 993, 097 | |
| .00 Tentative settlement (for contractor use only) | | | | 0 | 73 |
| .00 Balance due provider/program (line 71 minus lines 71.01, 71.02, 73) | | | | 72, 429 | |
| 00 Protested amounts (nonallowable cost report items) in accordance CMS Pub. 15-2, chapter 1, §115.2 | wi th | | | 100, 000 | 75 |
| TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) | 0.00 | | | - | 1 |
| 00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of plus 2.04 (see instructions) | 2.03 | | | 0 | |
| 00 Capital outlier from Wkst. L, Pt. I, line 2 | | | | 0 | 91 |
| 00 Operating outlier reconciliation adjustment amount (see instruct | | | | 0 | 92 |
| 00 Capital outlier reconciliation adjustment amount (see instructio | | | | 0 | 93 |
| 00 The rate used to calculate the time value of money (see instruct | ions) | | | 0.00 | |
| 00 Time value of money for operating expenses (see instructions) | | | | 0 | 95 |
| .00 Time value of money for capital related expenses (see instructio | ns) | | | 0 | 96 |
| | | | Prior to 10/1 | | |
| HSP Bonus Payment Amount | | | 1.00 | 2.00 | |
| 0.00 HSP bonus amount (see instructions) | | | | 0 | 100 |
| HVBP Adjustment for HSP Bonus Payment | | | | | 1.00 |
| 1.00 HVBP adjustment factor (see instructions) | | | | 0.000000000 | 1101 |
| 2.00 HVBP adjustment amount for HSP bonus payment (see instructions) | | | | | 102 |
| HRR Adjustment for HSP Bonus Payment | | | | | 102 |
| 3. 00 HRR adjustment factor (see instructions) | | | | 0.0000 | 1103 |
| 4.00 HRR adjustment amount for HSP bonus payment (see instructions) | | | | | 104 |
| Rural Community Hospital Demonstration Project (§410A Demonstrat | ion) Adius | tment | | | 104 |
| | ion) Auju. | | | | 200 |
|) OOLLS this the first year of the current 5-year demonstration perio | d under tl | | | | 200 |
| | d under t | 10 2131 | | | |
| Century Cures Act? Enter "Y" for yes or "N" for no. | d under t | | | L | |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement | | | | | 201 |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 | | | | | |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 2.00 Medicare discharges (see instructions) | | | | | 202 |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) | 9) | | t 5-year demonst | tration | 202 |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi | 9) | | t 5-year demonst | tration | 202 |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.000 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 2.000 Medicare discharges (see instructions) 3.000 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi period) | 9) | | t 5-year demonst | | 202 203 |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.000 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi period) 4.00 Medicare target amount | 9) | | t 5-year demonst | | 202 203 204 |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.000 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 2.000 Medicare discharges (see instructions) 3.000 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi period) 4.000 Medicare target amount 5.000 Case-mix adjusted target amount (line 203 times line 204) | 9) | | t 5-year demonst | | 202 203 204 204 |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.000 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 2.000 Medicare discharges (see instructions) 3.000 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi period) 4.000 Medicare target amount 5.000 Case-mix adjusted target amount (line 203 times line 204) | 9) | | t 5-year demonst | | 202 203 204 204 |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement | 9) rst year (| | t 5-year demonst | | 202 203 204 205 206 |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 2.00 Medicare discharges (see instructions) 2.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instruct | 9) rst year (tions) | | t 5-year demonst | | 202 203 204 205 206 207 |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instruct 3.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, li | 9) rst year (tions) | | t 5-year demonst | | 202 203 204 205 206 207 208 |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instruct 3.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, li 9.00 Adjustment to Medicare IPPS payments (see instructions) | 9) rst year (tions) | | t 5-year demonst | | 202 203 204 205 206 207 208 209 |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.000 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instruct 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, li 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use | 9) rst year (tions) | | t 5-year demonst | | 202 203 204 205 206 207 208 209 210 |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instruct 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, li 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Total adjustment to Medicare IPPS payments (see instructions) | 9) rst year (tions) | | t 5-year demonst | | 202 203 204 205 206 207 208 209 210 |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instruct 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, li 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement | 9) rst year o tions) ne 59) | | t 5-year demonst | | 202 203 204 205 206 207 208 209 210 211 |
| Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fiperiod) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instruct 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, li 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 2.00 Total adjustment to Medicare Part A IPPS payments (from line 211 | 9) rst year o tions) ne 59) | | t 5-year demonst | | 201 202 203 204 205 206 207 208 209 210 211 212 212 212 |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instruct 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, li 9.00 Adjustment to Medicare IPPS payments (see instructions) 9.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement | 9) rst year (tions) ne 59) | of the currer | t 5-year demonst | | 202 203 204 205 206 207 208 209 210 211 211 |

| OSPI T | TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA | TION EXHIBIT 5 | Provider CO | | Period: From 10/01/2017 | | |
|--------------|--|-------------------------|---------------------------------|--------------------|----------------------------|---------------------------------|------------|
| | | | | | To 09/30/2018 | Date/Time Pre 2/28/2019 1:02 | pared |
| | | | | XVIII | Hospi tal | PPS | |
| | | Wkst. E, Pt. A, line | Amt. from Wkst. E, Pt. A) | Period to 10/01 | Period on after 10/01 | Total (cols. 2 and 3) | |
| | | 0 | 1.00 | 2.00 | 3.00 | 4.00 | |
| . 00 | DRG amounts other than outlier payments | 1.00 | | | | | 1. C |
| . 01 | DRG amounts other than outlier payments for | 1.01 | 0 | | 0 | 0 | 1.0 |
| . 02 | discharges occurring prior to October 1 DRG amounts other than outlier payments for | 1.02 | 1, 630, 424 | | 1, 630, 424 | 1, 630, 424 | 1.0 |
| 03 | discharges occurring on or after October 1 DRG for Federal specific operating payment | 1.03 | 0 | | 0 | 0 | 1. (|
| | for Model 4 BPCI occurring prior to October 1 | | | | | | |
| . 04 | DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 | 1.04 | 0 | | 0 | 0 | 1.(|
| . 00 | Outlier payments for discharges (see | 2.00 | 25, 767 | | 0 25, 767 | 25, 767 | 2. |
| . 01 | instructions) Outlier payments for discharges for Model 4 | 2.02 | 0 | | 0 0 | 0 | 2. (|
| 00 | BPCI | 2 01 | 0 | | 0 | 0 | 3. (|
| . 00 . 00 | Operating outlier reconciliation Managed care simulated payments | 2.01 3.00 | 0 | | 0 0 0 0 | - | 3. 4. |
| | Indirect Medical Education Adjustment | 0100 | | | <u> </u> | | |
| 00 | Amount from Worksheet E, Part A, line 21 (see instructions) | 21.00 | 0. 000000 | 0. 00000 | 0 0. 000000 | | 5. |
| 00 | IME payment adjustment (see instructions) | 22.00 | 0 | | 0 0 | 0 | 6. |
| 01 | IME payment adjustment for managed care (see instructions) | 22.01 | 0 | | 0 0 | 0 | 6. |
| | Indirect Medical Education Adjustment for the | | | | _ | | |
| 00 | IME payment adjustment factor (see instructions) | 27.00 | 0. 000000 | 0. 00000 | 0 0. 000000 | | 7. |
| 00 | IME adjustment (see instructions) | 28.00 | 0 | | 0 0 | 0 | 8. |
| 01 | IME payment adjustment add on for managed care (see instructions) | 28.01 | 0 | | 0 0 | 0 | 8. |
| 00 | Total IME payment (sum of lines 6 and 8) | 29.00 | 0 | | 0 0 | 0 | 9. |
| 01 | Total IME payment for managed care (sum of lines 6.01 and 8.01) | 29.01 | 0 | | 0 0 | 0 | 9. |
| | Disproportionate Share Adjustment | 22.00 | 0 1200 | 0.100 | 0 0 1000 | | 1 10 |
| . 00 | Allowable disproportionate share percentage (see instructions) | 33.00 | 0. 1200 | 0. 120 | 0 0. 1200 | | 10. |
| . 00 | Disproportionate share adjustment (see instructions) | 34.00 | 48, 913 | | 0 48, 913 | 48, 913 | 11. |
| . 01 | Uncompensated care payments | 36.00 | 506, 210 | | 0 506, 210 | 506, 210 | 11. |
| | Additional payment for high percentage of ESR | D beneficiary | di scharges | | | | 1 |
| 2. 00 | Total ESRD additional payment (see instructions) | 46.00 | 0 | | 0 0 | 0 | 12. |
| 3. 00 | Subtotal (see instructions) | 47.00 | 2, 211, 314 | | 0 2, 211, 314 | 2, 211, 314 | 13 |
| | Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see | 48.00 | 0 | | 0 0 | | 14. |
| 5. 00 | instructions) Total payment for inpatient operating costs | 49.00 | 2, 211, 314 | | 0 2, 211, 314 | 2, 211, 314 | 15. |
| . 00 | (see instructions) Payment for inpatient program capital (from | 50.00 | 131, 478 | | 0 131, 478 | 131, 478 | 16. |
| . 00 | Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies Net organ acquisition cost | 54.00 | 0 | | 0 0 | 0 | 17. 17. |
| 7.01 7.02 | Credits received from manufacturers for replaced devices for applicable MS-DRGs | 68.00 | 0 | | 0 0 | 0 | |
| 3. 00 | | 93.00 | 0 | | o o | 0 | 18. |
| | | | | | | | |

| | AYETTE REGIONAL | | | | eu of Form CMS- | 2552-10 |
|--|-----------------|------------------------|-------------|---|-----------------------------|---------|
| HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA | TION EXHIBIT 5 | Provider CO | JN: 15-0064 | Period: From 10/01/201 To 09/30/201 | | 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 | 2.00 | 0 129, 53 | | 20.00 |
| 20.01 Model 4 BPCI Capital DRG other than outlier | 1.01 | 0 | | 0 | 0 0 | |
| 21.00 Capital DRG outlier payments | 2.00 | 1, 948 | | 0 1, 94 | 8 1, 948 | 21.00 |
| 21.01 Model 4 BPCI Capital DRG outlier payments | 2.01 | 0 | | 0 | 0 0 | 21.01 |
| 22.00 Indirect medical education percentage (see instructions) | 5.00 | 0.0000 | 0.000 | 0.000 | 0 | 22.00 |
| 23.00 Indirect medical education adjustment (see instructions) | 6.00 | 0 | | 0 | 0 0 | 23.00 |
| 24.00 Allowable disproportionate share percentage (see instructions) | 10.00 | 0.0000 | 0.000 | 0.000 | 0 | 24.00 |
| 25.00 Disproportionate share adjustment (see instructions) | 11.00 | 0 | | 0 | 0 0 | 25.00 |
| 26.00 Total prospective capital payments (see instructions) | 12.00 | 131, 478 | | 0 131, 47 | 8 131, 478 | 26.00 |
| | Wkst. E, Pt. | (Amt. from | | | | |
| | A, line | Wkst. E, Pt. A) | | | | |
| | 0 | 1.00 | 2.00 | 3.00 | 4.00 | |
| 27.00 | | | | | | 27.00 |
| 28.00 Low volume adjustment prior to October 1 | 70.96 | 0 | | 0 | 0 | |
| 29.00 Low volume adjustment on or after October 1 | 70.97 | 0 | | | 0 0 | 27.00 |
| 30.00 HVBP payment adjustment (see instructions) | 70. 93 | 12, 775 | | 0 12, 77 | 5 12, 775 | |
| 30.01 HVBP payment adjustment for HSP bonus payment (see instructions) | 70. 90 | 0 | | 0 | 0 0 | 30. 01 |
| 31.00 HRR adjustment (see instructions) | 70.94 | 0 | | 0 | 0 0 | 31.00 |
| 31.01 HRR adjustment for HSP bonus payment (see instructions) | 70. 91 | 0 | | 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 0 | 02.00 |
| 100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A. | | N | | | | 100. 00 |

| CALCUL | Financial Systems FAYETTE REGIONAL HEALTH S ATION OF REIMBURSEMENT SETTLEMENT Provi | der CCN: 15-0064 | Peri od: | Worksheet E | 1 |
|----------------|--|--------------------|----------------------------------|------------------------|----------------|
| | | | From 10/01/2017 To 09/30/2018 | | pared: |
| | | Title XVIII | Hospi tal | 2/28/2019 1:03 PPS | 2 pm |
| | | | iloopi tui | | |
| | PART B - MEDICAL AND OTHER HEALTH SERVICES | | | 1.00 | |
| 1.00 | Medical and other services (see instructions) | | | 10, 942 | 1.00 |
| 2.00 | Medical and other services reimbursed under OPPS (see instructions) | | | 8, 251, 626 | |
| 3.00 4.00 | OPPS payments Outlier payment (see instructions) | | | 4, 750, 042 11, 097 | 3.00 4.00 |
| 4.00 | Outlier reconciliation amount (see instructions) | | | 0 | |
| 5.00 | Enter the hospital specific payment to cost ratio (see instructions) | | | 0. 000 | |
| 6.00 | Line 2 times line 5 | | | 0 | |
| 7.00 8.00 | Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions) | | | 0. 00 0 | |
| 8.00 9.00 | Ancillary service other pass through costs from Wkst. D, Pt. IV, col | . 13. line 200 | | 0 | |
| 10.00 | Organ acqui si ti ons | 1 10, 1110 200 | | 0 | 10.00 |
| 11. 00 | Total cost (sum of lines 1 and 10) (see instructions) | | | 10, 942 | 11.00 |
| | COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges | | | | |
| 12.00 | Ancillary service charges | | | 28, 540 | 12.00 |
| 13.00 | Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) | | | 0 | 13.00 |
| 14.00 | Total reasonable charges (sum of lines 12 and 13) | | | 28, 540 | 14.00 |
| 15 00 | Customary charges | fan oanviege on | a abarga basi a | 0 | 15 00 |
| 15.00 16.00 | Aggregate amount actually collected from patients liable for payment Amounts that would have been realized from patients liable for payment | | | 0 | |
| 10.00 | had such payment been made in accordance with 42 CFR §413.13(e) | | on a chargebasi s | 0 | |
| 17.00 | Ratio of line 15 to line 16 (not to exceed 1.000000) | | | 0. 000000 | |
| 18.00 | Total customary charges (see instructions) | i | 11) (| 28, 540 | |
| 19.00 | Excess of customary charges over reasonable cost (complete only if l instructions) | The 18 exceeds TI | ne II) (see | 17, 598 | 19.00 |
| 20. 00 | Excess of reasonable cost over customary charges (complete only if I | ine 11 exceeds li | ne 18) (see | 0 | 20.00 |
| | instructions) | | | | |
| 21.00 22.00 | Lesser of cost or charges (see instructions) | | | 10, 942 0 | 21.00 |
| 22.00 | Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instruction | is) | | 0 | 22.00 |
| 24.00 | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) | , | | 4, 761, 139 | |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | _ | |
| 25.00 26.00 | Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (1 | For CAH soo inst | suctions) | 0 996, 533 | |
| 27.00 | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus th | | , | 3, 775, 548 | |
| | instructions) | | | | |
| 28.00 | Direct graduate medical education payments (from Wkst. E-4, line 50) | | | 0 | |
| 29.00 30.00 | ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) | | | 0 3, 775, 548 | |
| 31.00 | Primary payer payments | | | 3, 775, 548 | |
| 32.00 | | | | 3, 775, 548 | • |
| | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | | | | |
| 33.00 34.00 | Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) | | | 0 124, 457 | 33.00 34.00 |
| 35.00 | Adjusted reimbursable bad debts (see instructions) | | | 80, 897 | 35.00 |
| 36.00 | Allowable bad debts for dual eligible beneficiaries (see instruction | ıs) | | 124, 457 | |
| 37.00 | Subtotal (see instructions) | | | 3, 856, 445 | |
| 38.00 39.00 | MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | 38.00 39.00 |
| 39.50 | Pioneer ACO demonstration payment adjustment (see instructions) | | | 0 | 39.00 |
| 39.97 | Demonstration payment adjustment amount before sequestration | | | 0 | |
| 39. 98 | Partial or full credits received from manufacturers for replaced dev | /ices (see instruc | ctions) | 0 | 39.98 |
| 39.99 | RECOVERY OF ACCELERATED DEPRECIATION | | | 0 | 39.99 |
| 40.00 | Subtotal (see instructions) Sequestration adjustment (see instructions) | | | 3, 856, 445 77, 129 | 1 |
| 40. 02 | Demonstration payment adjustment amount after sequestration | | | 0 | |
| 41.00 | Interim payments | | | 3, 815, 079 | |
| 42.00 | Tentative settlement (for contractors use only) | | | 0 25 742 | |
| 43.00 44.00 | Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance wit | h CMS Pub 15-2 | chapter 1 | -35, 763 0 | |
| | §115. 2 | | | 0 | |
| | TO BE COMPLETED BY CONTRACTOR | | | | |
| 90.00 | Original outlier amount (see instructions) | | | 0 | |
| 91.00 92.00 | Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money | | | 0 | 91.00 92.00 |
| | Time Value of Money (see instructions) | | | 0.00 | |
| 93.00 | | | | | 94.00 |

| NALY | SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CC | N: 15-0064 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I Date/Time Prep 2/28/2019 1:02 | |
|--------------|--|-------------|------------|---|---|------------|
| | | Title | | Hospi tal | PPS | |
| | | Inpatient | t Part A | Par | tВ | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | |
| . 00 . 00 | Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero | | 1, 993, 09 | 0 | 3, 698, 269 0 | 1.0 2.0 |
| . 00 | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | 3. (|
| . 01 | ADJUSTMENTS TO PROVIDER | | | 0 09/30/2018 | 116, 810 | 3.0 |
| . 02 | | | | 0 | 0 | 3.0 |
| . 03 | | | | 0 | 0 | 3. |
| . 04 . 05 | | | | 0 | 0 | 3. 3. |
| . 05 | Provider to Program | <u> </u> | | | 0 | 5. |
| 50 | ADJUSTMENTS TO PROGRAM | | | 0 | 0 | 3. |
| 51 | | | | 0 | 0 | 3. |
| 52 | | | | 0 | 0 | 3. |
| . 53 . 54 | | | | 0 | 0 | 3. 3. |
| . 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines | | | 0 | 116, 810 | 3. |
| 00 | 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) | | 1, 993, 09 | 97 | 3, 815, 079 | 4. |
| | (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) | | | | | |
| 00 | TO BE COMPLETED BY CONTRACTOR 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) | | | | | Э. |
| 01 | Program to Provider TENTATIVE TO PROVIDER | | | 0 | 0 | 5. |
| 02 | | | | 0 | 0 | 5. |
| 03 | | | | 0 | 0 | 5. |
| | Provider to Program | <u>г</u> | | 0 | | - |
| 50 51 | TENTATI VE TO PROGRAM | | | 0 | 0 | 5. 5. |
| 52 | | | | 0 | 0 | 5. 5. |
| 99 | Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98) | | | 0 | 0 | 5. |
| 00 | Determined net settlement amount (balance due) based on the cost report. (1) | | | | | 6. |
| 01 | SETTLEMENT TO PROVIDER | | 72, 42 | | 0 | 6. |
| 02 00 | SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) | | 2,065,52 | 0 | 35, 763 3, 779, 316 | 6. 7. |
| 00 | Total meancare program traditity (see fistructions) | | 2,000,52 | Contractor Number | NPR Date (Mo/Day/Yr) | 1. |
| | | 0 | | 1.00 | 2.00 | |

| VALYS | SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CC Component C | CN: 15-0064 CCN: 15-S064 | Period: From 10/01/2017 To 09/30/2018 | | parec |
|----------|--|----------------------------|-----------------------------|---|---------------------|--------------|
| | | Ti tl e | XVIII | Subprovider - | PPS | 2 pm |
| | | Inpatien | t Part A | | rt B | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | |
| 00 00 | Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero | | 1, 384, 9 | 32 0 | 0 | 1. (2. (|
| 00 | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | 3. |
| 01 | ADJUSTMENTS TO PROVIDER | | | 0 | 0 | 3. |
| 02 | | | | 0 | 0 | 3. |
| 03 | | | | 0 | 0 | 3. |
| 04 | | | | 0 | 0 | 3. |
| 05 | Provider to Program | | | 0 | 0 | 3 |
| 50 | ADJUSTMENTS TO PROGRAM | | | 0 | 0 | 3 |
| 51 | | | | 0 | 0 | 3 |
| 52 | | | | 0 | 0 | |
| 53 | | | | 0 | 0 | 3 |
| 54 | | | | 0 | 0 | 3 |
| 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines | | | 0 | 0 | 3 |
| | 3. 50-3. 98) | | | | | |
| 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, 9 | 32 | 0 | 4 |
| | TO BE COMPLETED BY CONTRACTOR | | | | | |
| 00 | List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | | | | 5. |
| | Program to Provider | | | | | |
|)1 | TENTATI VE TO PROVIDER | | | 0 | 0 | |
|)2 | | | | 0 | 0 | |
|)3 | Describer to Descrean | | | 0 | 0 | 5 |
| | Provider to Program TENTATIVE TO PROGRAM | | | 0 | 0 | |
| 50 51 | ILIVIATIVE TO PROURAW | | | 0 | 0 | 5 |
| 52 | | | | 0 | 0 | |
| 9 | Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98) | | | 0 | 0 | 5 |
| 00 | Determined net settlement amount (balance due) based on the cost report. (1) | | | | | 6 |
| 01 | SETTLEMENT TO PROVIDER | | | 2 | 0 | |
| 02 | SETTLEMENT TO PROGRAM | | | 0 | 0 | - |
| 00 | Total Medicare program liability (see instructions) | | 1, 384, 9 | | 0 | 7 |
| | | | | Contractor | NPR Date | |
| | | | | <u>Number</u> 1.00 | (Mo/Day/Yr) 2.00 | |

| NALY: | SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CC Component C | | | eriod: com 10/01/2017 o 09/30/2018 | | pared |
|--------------|--|----------------------------|--------|----------|--|-------------------------|-------|
| | | | XV/LLL | <u> </u> | ing Dodo _ CNE | 2/28/2019 1:0 | 2 pm |
| | | | | ISW | <u>ing Beds - SNF</u> Par | PPS t B | |
| | | · | | | | - | |
| | | mm/dd/yyyy | Amount | | mm/dd/yyyy | Amount | |
| 00 | Total interim normente neid te provider | 1.00 | 2.00 | 0 | 3.00 | 4.00 | 1.0 |
| . 00 | Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero | | | 0 | | 0 0 | |
| . 00 | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | | 3.0 |
| . 01 | ADJUSTMENTS TO PROVIDER | | | 0 | | 0 | 3.0 |
| . 02 | ABSOSTMENTS TO TROVIDER | | | 0 | | 0 | |
| . 03 | | | | 0 | | 0 | |
| . 04 | | | | 0 | | 0 | |
| . 05 | Drovidor to Drogram | | | 0 | | 0 | 3.0 |
| 50 | Provider to Program ADJUSTMENTS TO PROGRAM | | | 0 | | 0 | 3. |
| 51 | | | | 0 | | 0 | |
| 52 | | | | 0 | | 0 | |
| 53 | | | | 0 | | 0 | |
| . 54 . 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines | | | 0 | | 0 | |
| . 99 | 3. 50-3. 98) | | | 0 | | 0 | 3. |
| 00 | Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) | | | 0 | | 0 | 4. (|
| | TO BE COMPLETED BY CONTRACTOR | | | | | | |
| 00 | List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | | 5. (|
| 01 | TENTATI VE TO PROVI DER | | | 0 | | 0 | 5.0 |
| 02 | | | | 0 | | 0 | |
| 03 | | | | 0 | | 0 | 5. |
| 50 | Provider to Program | | | 0 | | - | - 1 |
| 50 51 | TENTATI VE TO PROGRAM | | | 0 | | 0 | |
| 52 | | | | 0 | | 0 | |
| 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines | | | 0 | | 0 | |
| 00 | 5.50-5.98) Determined net settlement amount (balance due) based on | | | | | | 6. |
| 01 | the cost report. (1) SETTLEMENT TO PROVIDER | | | 0 | | 0 | 6. |
| 02 | SETTLEMENT TO PROVIDER | | | 0 | | 0 | |
| 00 | Total Medicare program liability (see instructions) | | | 0 | | 0 | |
| | | | | | Contractor Number | NPR Date (Mo/Day/Yr) | |
| | | 0 | | | 1.00 | 2.00 | |

| Heal th | Financial Systems FAYETTE REGIONAL HE | EALTH SYSTEM | In Lie | u of Form CMS- | 2552-10 | |
|---------|--|--------------------------|----------------------------|--------------------------------|---------|--|
| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT | Provider CCN: 15-0064 | Period: From 10/01/2017 | Worksheet E-1 Part II | | |
| | | | | Date/Time Pre 2/28/2019 1:0 | | |
| | | Title XVIII | Hospi tal | PPS | | |
| | | | | | | |
| | | | | 1.00 | | |
| | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS | | | | - | |
| | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION | | | | 1.00 | |
| 1.00 | | | | | | |
| 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 [| ine 20 | | | 6.00 | |
| 7.00 | CAH only - The reasonable cost incurred for the purchase of co line 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 | Calculation of the HIT incentive payment after sequestration | (see instructions) | | | 10.00 | |
| | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH | | | | 1 | |
| 30.00 | Initial/interim HIT payment adjustment (see instructions) | | | | 30.00 | |
| | Other Adjustment (specify) | | | | 31.00 | |
| | Balance due provider (line 8 (or line 10) minus line 30 and l | ine 31) (see instruction | s) | | 32.00 | |
| | | | - | | | |

| ALCULA | TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-0064 | Period: From 10/01/20 | Worksheet E-2 | 2 |
|--------|--|-------------------------|--------------------------|---------------|--------------|
| | | Component CCN: 15-U064 | To 09/30/20 | | |
| | | Title XVIII | Swing Beds - S | NF PPS | |
| | | | Part A | Part B | |
| | COMPLITATION OF NET COST OF COVEDED SEDVICES | | 1.00 | 2.00 | - |
| | COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions) | | | 0 0 | 1.0 |
| | Inpatient routine services - swing bed SM (see instructions) | | | | 2.0 |
| | Ancillary services (from Wkst. D-3, col. 3, line 200, for Part | A, and sum of Wkst. D, | | | 3.0 |
| | Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins | tructions) | | | |
| | Per diem cost for interns and residents not in approved teachin | ng program (see | | 0.00 | 4.0 |
| | instructions) | | | | |
| | Program days Interns and residents not in approved teaching program (see in: | structions) | | 0 0 | |
| 1 | Utilization review - physician compensation - SNF optional met | - | | 0 | 7.0 |
| | Subtotal (sum of lines 1 through 3 plus lines 6 and 7) | | | 0 0 | |
| .00 | Primary payer payments (see instructions) | | | 0 0 | 9.0 |
| | Subtotal (line 8 minus line 9) | | | 0 0 | |
| | Deductibles billed to program patients (exclude amounts applica | able to physician | | 0 0 |) 11. (|
| 1 | professional services) Subtotal (line 10 minus line 11) | | | 0 0 | 12.0 |
| 1 | Coinsurance billed to program patients (from provider records) | (exclude coinsurance | | | |
| | for physician professional services) | | | | |
| | 80% of Part B costs (line 12 x 80%) | | | 0 | 14. |
| | Subtotal (enter the lesser of line 12 minus line 13, or line 14 | 4) | | 0 0 | |
| | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 0 | |
| | Pioneer ACO demonstration payment adjustment (see instructions) | e | | | 16. |
| | Rural community hospital demonstration project (§410A Demonstra adjustment (see instructions) | ation) payment | | 0 | 16. |
| 1 | Demonstration payment adjustment amount before sequestration | | | 0 0 | 16. |
| | Allowable bad debts (see instructions) | | | 0 0 | |
| 1 | Adjusted reimbursable bad debts (see instructions) | | | 0 0 | 17. |
| 1 | Allowable bad debts for dual eligible beneficiaries (see instru | uctions) | | 0 0 | |
| | Total (see instructions) | | | 0 0 | |
| | Sequestration adjustment (see instructions) | | | 0 0 | |
| | Demonstration payment adjustment amount after sequestration) Interim payments | | | 0 0 | |
| | Tentative settlement (for contractor use only) | | | | |
| | Balance due provider/program (line 19 minus lines 19.01, 20, a | nd 21) | | 0 0 | |
| | Protested amounts (nonallowable cost report items) in accordance | | | 0 0 | 23. |
| | chapter 1, §115.2 | | | | |
| | Rural Community Hospital Demonstration Project (§410A Demonstra | | | | |
| | Is this the first year of the current 5-year demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. | iod under the 21st | | | 200. |
| | Cost Reimbursement | | | | |
| | Medicare swing-bed SNF inpatient routine service costs (from W | kst. D-1, Pt. II, line | | | 201. |
| | 66 (title XVIII hospital)) | | | | |
| | Medicare swing-bed SNF inpatient ancillary service costs (from | Wkst. D-3, col. 3, lin | е | | 202. |
| | 200 (title XVIII swing-bed SNF)) | | | | 202 |
| 1 | Total (sum of lines 201 and 202) Modicara swing bod SNE discharges (see instructions) | | | | 203. 204. |
| | Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in 1 | first year of the curre | nt 5-vear demor | stration | 204. |
| | peri od) | inst year of the earre | int o year demor | istruction . | |
|)5.00 | Medicare swing-bed SNF target amount | | | | 205. |
| | Medicare swing-bed SNF inpatient routine cost cap (line 205 tin | | | | 206. |
| | Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse | | | | 1007 |
| | Program reimbursement under the §410A Demonstration (see instru Medicare swing bod SNE inpatient cervice cests (from Wkst E 2 | | 1 | | 207. |
| | Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, and 3) | , COL. I, SUM OF LINES | 1 | | 208. |
| | Adjustment to Medicare swing-bed SNF PPS payments (see instruc | tions) | | | 209. |
| | Reserved for future use | / | | | 210. |
| | Comparision of PPS versus Cost Reimbursement | | | | |
| | Total adjustment to Medicare swing-bed SNF PPS payment (line 20 | 09 plus line 210) (see | | | 215. |

| LCULA | TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-0064 | Peri od: | Worksheet E-2 |
|-------|--|------------------------|----------------------------------|--------------------------------------|
| | | Component CCN: 15-UO64 | From 10/01/2017 To 09/30/2018 | Date/Time Prepar 2/28/2019 1:02 p |
| | | Title XIX | Swing Beds - SNF | |
| | | | Part A | Part B |
| | | | 1.00 | 2.00 |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | | |
| | Inpatient routine services - swing bed-SNF (see instructions) | | 0 | |
| | Inpatient routine services - swing bed-NF (see instructions) Ancillary services (from Wkst. D-3, col. 3, line 200, for Part | A and sum of West D | 0 | |
| | Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst | | 0 | |
| 00 | er diem cost for interns and residents not in approved teachin instructions) | | 0.00 | |
| 00 | Program days | | 0 | |
| 00 | Interns and residents not in approved teaching program (see ins | structions) | 0 | |
| | Jtilization review - physician compensation - SNF optional meth | iod only | 0 | |
| | Subtotal (sum of lines 1 through 3 plus lines 6 and 7) | | 0 | |
| | Primary payer payments (see instructions) | | 0 | |
| | Subtotal (line 8 minus line 9) | | 0 | 1 |
| | Deductibles billed to program patients (exclude amounts applica professional services) | ibi e to physi ci an | 0 | 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%) | | 0 | 1 |
| . 00 | Subtotal (enter the lesser of line 12 minus line 13, or line 14 | .) | 0 | 1 |
| . 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | 0 | 1 |
| . 50 | Pioneer ACO demonstration payment adjustment (see instructions) | | | 1 |
| | Rural community hospital demonstration project (§410A Demonstra | ition) payment | | 1 |
| | adjustment (see instructions) | | | |
| | Demonstration payment adjustment amount before sequestration | | 0 | 1 |
| | Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) | | 0 | 1 |
| | Allowable bad debts for dual eligible beneficiaries (see instru | uctions) | 0 | 1 |
| | Total (see instructions) | | 0 | 1 |
| | Sequestration adjustment (see instructions) | | 0 | 1 |
| | Demonstration payment adjustment amount after sequestration) | | 0 | 1 |
| | Interim payments | | 0 | 2 |
| 00 | Tentative settlement (for contractor use only) | | 0 | 2 |
| | Balance due provider/program (line 19 minus lines 19.01, 20, an | | 0 | 2 |
| | Protested amounts (nonallowable cost report items) in accordanc chapter 1, §115.2 | e with CMS Pub. 15-2, | 0 | 2 |
| | Rural Community Hospital Demonstration Project (§410A Demonstra | | T | |
| | Is this the first year of the current 5-year demonstration peri | od under the 21st | | 20 |
| | Century Cures Act? Enter "Y" for yes or "N" for no. | | | |
| | Medicare swing-bed SNF inpatient routine service costs (from Wk | st. D-1. Pt. II. line | | 20 |
| | 66 (title XVIII hospital)) | | | 20 |
| | Medicare swing-bed SNF inpatient ancillary service costs (from | Wkst. D-3, col. 3, lin | e | 20 |
| | 200 (title XVIII swing-bed SNF)) | | | |
| | Total (sum of lines 201 and 202) | | | 20 |
| | Medicare swing-bed SNF discharges (see instructions) | | | 20 |
| | Computation of Demonstration Target Amount Limitation (N/A in f | irst year of the curre | nt 5-year demonst | ration |
| | period) Medicare swing-bed SNF target amount | | | 20 |
| | Medicare swing-bed SNF inpatient routine cost cap (line 205 tim | nes line 204) | | 20 |
| | djustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse | | | |
| | Program reimbursement under the §410A Demonstration (see instru | | | 20 |
| | Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, | col. 1, sum of lines | 1 | 20 |
| | and 3) | | | |
| | Adjustment to Medicare swing-bed SNF PPS payments (see instruct | ions) | | 20 |
| | Reserved for future use | | | 21 |
| | Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line 20 | 0 plus line 210) (| | |
| | instructions) | , pius ime 210) (See | | 21 |

| LCUL | Financial Systems FAYETTE REGIONAL I ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0064 | Period: | u of Form CMS-2 Worksheet E-3 | |
|----------|---|---------------------------------------|----------------------------------|---|----------|
| | | Component CCN: 15-SO64 | From 10/01/2017 To 09/30/2018 | Part II Date/Time Pre 2/28/2019 1:0 | |
| | | Title XVIII | Subprovider - IPF | PPS | <u> </u> |
| | | | | 1.00 | |
| | PART II - MEDICARE PART A SERVICES - IPF PPS | | | | |
| 00 | Net Federal IPF PPS Payments (excluding outlier, ECT, and me | dical education payments) | | 1, 522, 338 | |
| 00 | Net IPF PPS Outlier Payments | | | 30, 979 | |
| 00 | Net IPF PPS ECT Payments | | | 0 | |
| 00 | Unweighted intern and resident FTE count in the most recent 15, 2004. (see instructions) | cost report filed on or b | efore November | 0.00 | 4 |
| 01 | Cap increases for the unweighted intern and resident FTE cou program or hospital closure, that would not be counted witho CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) | | | 0.00 | 4 |
| 00 | New Teaching program adjustment. (see instructions) | | | 0.00 | 5 |
| 00 | Current year's unweighted FTE count of I&R excluding FTEs in | the new program growth p | eriod of a "new | 0.00 | |
| 00 | teaching program" (see instuctions) Current year's unweighted I&R FTE count for residents within | the new program growth p | eriod of a "new | 0.00 | |
| - | teaching program" (see instuctions) | , <u> </u> | | 2.00 | |
| 00 | Intern and resident count for IPF PPS medical education adju | stment (see instructions) | | 0.00 | 8 |
| 00 | Average Daily Census (see instructions) | | | 0.830137 | |
| 00 | Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to | the power of .5150 -1}. | | 0.00000 | |
| 00 | Teaching Adjustment (line 1 multiplied by line 10). | | | 0 | 1 |
| 00 | Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) | | | 1, 553, 317 | 1: |
| 00 | Nursing and Allied Health Managed Care payment (see instruct | i on) | | 0 | 1 |
| | Organ acquisition (DO NOT USE THIS LINE) | tructione) | | 0 | 14 |
| 00 00 | Cost of physicians' services in a teaching hospital (see ins Subtotal (see instructions) | tructions) | | 0 1, 553, 317 | 1! |
| 00 | Primary payer payments | | | 1, 555, 517 | 1 |
| 00 | Subtotal (line 16 less line 17). | | | 1, 553, 317 | |
| 00 | Deducti bl es | | | 100, 912 | |
| 00 | Subtotal (line 18 minus line 19) | | | 1, 452, 405 | |
| 00 | Coinsurance | | | 39, 207 | 2 |
| 00 | Subtotal (line 20 minus line 21) | | | 1, 413, 198 | 2 |
| 00 | Allowable bad debts (exclude bad debts for professional serv | ices) (see instructions) | | 0 | 2 |
| 00 | Adjusted reimbursable bad debts (see instructions) | | | 0 | 2 |
| 00 | 5 | tructions) | | 0 | 2 |
| 00 | Subtotal (sum of lines 22 and 24) | | | 1, 413, 198 | |
| 00 | Direct graduate medical education payments (from Wkst. E-4, | line 49) | | 0 | 2 |
| 00 00 | Other pass through costs (see instructions) | | | 0 | 2 |
| 00 | Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | 3 |
| 50 | Pioneer ACO demonstration payment adjustment (see instructio | ns) | | 0 | 30 |
| 99 | Demonstration payment adjustment amount before sequestration | | | 0 | |
| 00 | Total amount payable to the provider (see instructions) | | | 1, 413, 198 | |
| 01 | Sequestration adjustment (see instructions) | | | 28, 264 | |
| 02 | Demonstration payment adjustment amount after sequestration | | | 0 | 3 |
| 00 | Interim payments | | | 1, 384, 932 | |
| | Tentative settlement (for contractor use only) | | | 0 | |
| . 00 | Balance due provider/program (line 31 minus lines 31.01, 31. | · · · · · · · · · · · · · · · · · · · | | 2 | 34 |
| . 00 | Protested amounts (nonallowable cost report items) in accord §115.2 | ance with CMS Pub. 15-2, | chapter 1, | 0 | 35 |
| 00 | TO BE COMPLETED BY CONTRACTOR Original outlier amount from Worksheet E-3, Part II, line 2 | | | 30, 979 | 50 |
| | | | | 30, 979 | 5 |
| . 00 | The rate used to calculate the Time Value of Money | | | 0.00 | |
| | Time Value of Money (see instructions) | | | | 53 |

| CALCULATION OF REIMBURSEMENT SETTLEMENT | | Provider CCN: 15-0064 | Period: | Worksheet E-3 | |
|---|---|-------------------------------|----------------------------------|---|-------|
| | | Component CCN: 15-TO64 | From 10/01/2017 To 09/30/2018 | Part III Date/Time Pre 2/28/2019 1:03 | parec |
| | | Title XVIII | Subprovider - | PPS | 2 pm |
| | | | | 1.00 | |
| | PART III - MEDICARE PART A SERVICES - IRF PPS | | | | |
| . 00 | Net Federal PPS Payment (see instructions) | | | 0 | |
| . 00 | Medicare SSI ratio (IRF PPS only) (see instructions) | | | 0.0000 | 2. |
| . 00 | Inpatient Rehabilitation LIP Payments (see instructions) | | | 0 | 3. |
| . 00 | Outlier Payments | | | 0 | 4. |
| . 00 | Unweighted intern and resident FTE count in the most rec to November 15, 2004 (see instructions) | | 0 | 0.00 | 5. |
| . 01 | Cap increases for the unweighted intern and resident FTE program or hospital closure, that would not be counted w CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) | ithout a temporary cap adjust | | 0.00 | 5. |
| . 00 | New Teaching program adjustment. (see instructions) | | | 0.00 | 6. |
| . 00 | Current year's unweighted FTE count of I&R excluding FTE | s in the new program growth r | eriod of a "new | 0.00 | 7. |
| | teaching program" (see instructions) | | | 0.00 | `` |
| . 00 | Current year's unweighted I&R FTE count for residents wi teaching program" (see instructions) | thin the new program growth p | period of a "new | 0.00 | 8. |
| 00 | Intern and resident count for IRF PPS medical education | adjustment (see instructions) | | 0.00 | 9 |
| 0. 00 | Average Daily Census (see instructions) | , | | 0.00000 | 10 |
| 1.00 | Teaching Adjustment Factor (see instructions) | | | 0.00000 | 11 |
| . 00 | Teaching Adjustment (see instructions) | | | 0 | 12 |
| . 00 | Total PPS Payment (see instructions) | | | 0 | 13 |
| 1.00 | Nursing and Allied Health Managed Care payments (see ins | struction) | | 0 | 14 |
| 5.00 | Organ acquisition (DO NOT USE THIS LINE) | | | | 15 |
| 6. 00 | | instructions) | | 0 | |
| . 00 | , | | | 0 | |
| 3. 00 | 51515 | | | 0 | |
| . 00 | | | | 0 | |
|). 00 | | | | 0 | |
| . 00 | · · · · · · · · · · · · · · · · · · · | | | 0 | |
| 2.00 | | | | 0 | |
| 8.00 | | | | 0 | |
| . 00 | | services) (see instructions) | | 0 | |
| . 00 | 5 | | | 0 | |
| . 00 | 5 | (Instructions) | | 0 | |
| . 00 | | 4 15 40 | | 0 | |
| 3. 00 9. 00 | 5 | -4, 11110 49) | | 0 | |
| , 00), 00 | 1 5 1 | | | 0 | 30 |
| . 00 | | | | 0 | 31 |
| . 50 | | uctions) | | 0 | |
| . 99 | | | | 0 | |
| 2.00 | 1 5 5 | | | 0 | |
| 2. 01 | | | | 0 | |
| | Demonstration payment adjustment amount after sequestrat | i on | | 0 | |
| | Interim payments | | | 0 | |
| 1.00 | | | | 0 | |
| 5. 00 | | 32.02, 33, and 34) | | 0 | |
| 5. 00 | | | chapter 1, | 0 | |
| | TO BE COMPLETED BY CONTRACTOR | | | |] |
| 0. 00 | Original outlier amount from Wkst. E-3, Pt. III, line 4 | | | 0 | 50 |
| 1. 00 | Outlier reconciliation adjustment amount (see instructio | ns) | | 0 | |
| 2.00 | The rate used to calculate the Time Value of Money | | | 0.00 | |
| | Time Value of Money (see instructions) | | | 0 | 53 |

| LCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0064 | Peri od: | Worksheet E-3 | |
|--------------|---|-------------------------|----------------------------------|--|-------|
| | | | From 10/01/2017 To 09/30/2018 | Part VII Date/Time Pre 2/28/2019 1:0 | pare |
| | | Title XIX | Hospi tal | Cost | 2 pm |
| | | | Inpati ent | Outpati ent | |
| | | | 1.00 | 2.00 | |
| | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV | /ICES FOR TITLES V OR > | (IX SERVICES | | |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | | | |
| 00 | Inpatient hospital/SNF/NF services | | 297, 142 | | 1. |
| 00 | Medical and other services | | | 0 | |
| 00 00 | Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3) | | 0 297, 142 | 0 | 3. |
| 00 | Inpatient primary payer payments | | 277, 142 | 0 | 5. |
| 00 | Outpatient primary payer payments | | 0 | 0 | 6. |
| 00 | Subtotal (line 4 less sum of lines 5 and 6) | | 297, 142 | 0 | |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | · · · | | |
| | Reasonabl e Charges | | | | |
| 00 | Routine service charges | | 90, 975 | | 8. |
| 00 | Ancillary service charges | | 688, 715 | 0 | |
| . 00 | Organ acquisition charges, net of revenue | | 0 | | 10 |
| . 00 | Incentive from target amount computation | | 0 | 0 | 11 |
| . 00 | Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES | | 779, 690 | 0 | 12 |
| . 00 | Amount actually collected from patients liable for payment for | services on a charge | 0 | 0 | 13 |
| . 00 | basi s | services on a charge | 0 | 0 | '' |
| . 00 | Amounts that would have been realized from patients liable for | payment for services of | on 0 | 0 | 14 |
| | a charge basis had such payment been made in accordance with 42 | | | | |
| . 00 | Ratio of line 13 to line 14 (not to exceed 1.000000) | | 0. 000000 | 0.00000 | 15 |
| . 00 | Total customary charges (see instructions) | | 779, 690 | 0 | 16 |
| . 00 | Excess of customary charges over reasonable cost (complete only | y if line 16 exceeds | 482, 548 | 0 | 17 |
| 00 | line 4) (see instructions) | if line 4 evende lin | | 0 | 10 |
| . 00 | Excess of reasonable cost over customary charges (complete only 16) (see instructions) | y if line 4 exceeds iir | ne 0 | 0 | 18 |
| . 00 | Interns and Residents (see instructions) | | 0 | 0 | 19 |
| . 00 | Cost of physicians' services in a teaching hospital (see instru | uctions) | 0 | 0 | 20 |
| . 00 | Cost of covered services (enter the lesser of line 4 or line 10 | - | 297, 142 | 0 | |
| | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be o | * | | | 1 |
| . 00 | Other than outlier payments | | 0 | 0 | 22 |
| . 00 | Outlier payments | | 0 | 0 | |
| . 00 | Program capital payments | | 0 | | 24 |
| . 00 | Capital exception payments (see instructions) | | 0 | | 25 |
| . 00 | Routine and Ancillary service other pass through costs | | 0 | 0 | |
| . 00 . 00 | Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only) | | 0 | 0 | 27 |
| . 00 | Titles V or XIX (sum of lines 21 and 27) | | 297, 142 | 0 | |
| . 00 | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | 277,112 | | 1 ~ ' |
| . 00 | Excess of reasonable cost (from line 18) | | 0 | 0 | 30 |
| . 00 | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) | | 297, 142 | 0 | 31 |
| . 00 | Deducti bl es | | 0 | 0 | |
| . 00 | Coinsurance | | 0 | 0 | 33 |
| . 00 | Allowable bad debts (see instructions) | | 0 | 0 | |
| . 00 | Utilization review | | 0 | _ | 35 |
| . 00 | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and | 33) | 297, 142 | 0 | |
| . 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | 0 | 0 | |
| . 00 . 00 | Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4) | | 297, 142 | 0 | 38 |
| . 00 | Total amount payable to the provider (sum of lines 38 and 39) | | 297, 142 | 0 | |
| . 00 | Interim payments | | 463, 571 | 0 | 40 |
| . 00 | Balance due provider/program (line 40 minus line 41) | | -166, 429 | 0 | |
| . 00 | Protested amounts (nonallowable cost report items) in accordance | ce with CMS Pub 15-2 | 00, 127 | 0 | 43 |
| | chapter 1, §115.2 | | | - | 1 |

| LCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0064 | Period: From 10/01/2017 | Worksheet E-3 Part VII | |
|----------|---|----------------------------|----------------------------|--------------------------------|-----|
| | | Component CCN: 15-SO64 | To 09/30/2018 | Date/Time Pre 2/28/2019 1:0 | |
| | | Title XIX | Subprovider - IPF | Cost | |
| | | | Inpati ent | Outpati ent | |
| | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S | FRVICES FOR TITLES V OR X | 1.00 | 2.00 | |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | | | 1 |
| 00 | Inpatient hospital/SNF/NF services | | 14, 457 | | 1 |
| 00 | Medical and other services | | | 0 | 2 |
| 00 | Organ acquisition (certified transplant centers only) | | 0 | | 1 |
| 00 | Subtotal (sum of lines 1, 2 and 3) | | 14, 457 | 0 | 4 |
| 00 | Inpatient primary payer payments | | 0 | 0 | |
| 00 00 | Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6) | | 14, 457 | 0 | |
| 00 | COMPUTATION OF LESSER OF COST OR CHARGES | | 14, 457 | 0 | ' |
| | Reasonable Charges | | | | |
| 00 | Routi ne servi ce charges | | 962 | | 1 8 |
| 00 | Ancillary service charges | | 5, 502 | 0 | |
| . 00 | Organ acquisition charges, net of revenue | | 0 | | 10 |
| . 00 | Incentive from target amount computation | | 0 | | 1 |
| . 00 | Total reasonable charges (sum of lines 8 through 11) | | 6, 464 | 0 | 1: |
| ~~ | CUSTOMARY CHARGES | | | | 1 1 |
| . 00 | Amount actually collected from patients liable for payment f basis | or services on a charge | 0 | 0 | 13 |
| 00 | Amounts that would have been realized from patients liable f | for payment for services o | n 0 | 0 | 14 |
| 00 | a charge basis had such payment been made in accordance with | | | 0 | Ι. |
| . 00 | Ratio of line 13 to line 14 (not to exceed 1.000000) | | 0. 000000 | 0.000000 | 1! |
| . 00 | Total customary charges (see instructions) | | 6, 464 | 0 | 1 |
| . 00 | Excess of customary charges over reasonable cost (complete o | nly if line 16 exceeds | 0 | 0 | 1 |
| | line 4) (see instructions) | | | _ | |
| . 00 | Excess of reasonable cost over customary charges (complete o | only if line 4 exceeds lin | e 7, 993 | 0 | 18 |
| . 00 | 16) (see instructions) Interns and Residents (see instructions) | | 0 | 0 | 19 |
| . 00 | Cost of physicians' services in a teaching hospital (see ins | tructions) | 0 | 0 | 20 |
| . 00 | Cost of covered services (enter the lesser of line 4 or line | | 6, 464 | 0 | |
| | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only b | | ders. | | 1 |
| . 00 | Other than outlier payments | | 0 | 0 | |
| . 00 | Outlier payments | | 0 | 0 | |
| 00 | Program capital payments | | 0 | | 24 |
| . 00 | Capital exception payments (see instructions) | | 0 | 0 | 2! |
| . 00 | Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26) | | 0 | 0 | 26 |
| . 00 | Customary charges (title V or XIX PPS covered services only) | | 0 | 0 | 28 |
| | Titles V or XIX (sum of lines 21 and 27) | | 6, 464 | 0 | |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | 0,101 | | |
| . 00 | | | 7, 993 | 0 | 30 |
| . 00 | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and | 6) | 6, 464 | 0 | |
| | Deducti bl es | | 0 | 0 | |
| 00 | | | 0 | 0 | |
| 00 | Allowable bad debts (see instructions) | | 0 | 0 | |
| 00 | Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a | and 33) | | 0 | 35 |
| . 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | inu 55 <i>)</i> | 6, 464 | 0 | |
| . 00 | Subtotal (line 36 \pm line 37) | | 6, 464 | 0 | |
| . 00 | Direct graduate medical education payments (from Wkst. E-4) | | 0 | 0 | 30 |
| . 00 | Total amount payable to the provider (sum of lines 38 and 39 |)) | 6, 464 | 0 | |
| . 00 | Interim payments | | 3, 853 | 0 | 4 |
| . 00 | Balance due provider/program (line 40 minus line 41) | | 2, 611 | 0 | 42 |
| . 00 | Protested amounts (nonallowable cost report items) in accord | lance with CMS Dub 15 2 | 0 | 0 | 43 |

| | E SHEET (If you are nonproprietary and do not maintain | Provider C | | eri od: | Worksheet G | |
|----------------|--|---------------|--------------|--------------------------------|---------------|------|
| und-1 nl y) | ype accounting records, complete the General Fund column | | | rom 10/01/2017 o 09/30/2018 | | par |
| 11 y) | | General Fund | Speci fi c | Endowment Fund | 2/28/2019 1:0 | 2 pi |
| | | General Fund | Purpose Fund | | | |
| | CUDDENT ACCETC | 1.00 | 2.00 | 3.00 | 4.00 | |
| 00 | CURRENT ASSETS Cash on hand in banks | 2, 826, 755 | | 0 | 0 | 1 1 |
| 00 | Temporary investments | 2,020,700 | | | 0 | |
| 00 | Notes receivable | C |) C | 0 | 0 | 3 |
| 00 | Accounts receivable | 20, 431, 781 | C | 0 | 0 | 4 |
| 00 | Other receivable | 1, 539, 563 | C C | 0 | 0 | 1 |
| 00 | Allowances for uncollectible notes and accounts receivable | -11, 198, 627 | | 0 | 0 | |
| 00 | Inventory | 767, 537 | | 0 | 0 | |
| 00 | Prepaid expenses | 710, 651 | | 0 | 0 | 8 |
| 00). 00 | Other current assets Due from other funds | | | 0 | 0 | 10 |
| . 00 | Total current assets (sum of lines 1-10) | 15, 077, 660 | | - | 0 | |
| . 00 | FIXED ASSETS | 13, 077, 000 | ή (| vi Vi | 0 | 1' |
| 2. 00 | Land | 1, 495, 800 | | o | 0 | 1 1: |
| 3. 00 | Land improvements | C | | 0 | 0 | |
| 1.00 | Accumulated depreciation | C |) C | 0 | 0 | 14 |
| 5.00 | Bui I di ngs | 53, 295, 798 | C C | 0 | 0 | 1! |
| 5.00 | Accumulated depreciation | -53, 701, 825 | | 0 | 0 | 10 |
| 7.00 | Leasehold improvements | 7, 602, 966 | | 0 | 0 | 1 |
| 3.00 | Accumulated depreciation | C | | - | 0 | 18 |
| 9.00 0.00 | Fixed equipment Accumulated depreciation | | | - | 0 | 10 |
| | Automobiles and trucks | | | 0 | 0 | 2 |
| | Accumulated depreciation | | | 0 | 0 | 2 |
| | Major movable equipment | 18, 492, 028 | | 0 | 0 | 2 |
| | Accumulated depreciation | C | | 0 | 0 | 2 |
| 5.00 | Minor equipment depreciable | C |) C | 0 | 0 | 2! |
| 5.00 | Accumulated depreciation | C |) C | 0 | 0 | 20 |
| | HIT designated Assets | C | C | 0 | 0 | 2 |
| | Accumulated depreciation | C | C | 0 | 0 | 2 |
| 9.00 | Minor equipment-nondepreciable | 0 |) C | | 0 | |
| 0.00 | Total fixed assets (sum of lines 12-29) | 27, 184, 767 | C | 0 | 0 | 30 |
| 1.00 | OTHER ASSETS Investments | 198, 863 | | ol | 0 | 3 |
| 2.00 | Deposits on Leases | 190, 000 | | | 0 | 32 |
| 3.00 | Due from owners/officers | C | | 0 | 0 | |
| 4.00 | Other assets | 1, 376, 058 | c c | 0 | 0 | 34 |
| 5.00 | Total other assets (sum of lines 31-34) | 1, 574, 921 | | 0 | 0 | 35 |
| 6.00 | Total assets (sum of lines 11, 30, and 35) | 43, 837, 348 | C C | 0 | 0 | 36 |
| | CURRENT LIABILITIES | | | | | |
| | Accounts payable | 11, 839, 067 | | - | 0 | |
| 3.00 | Salaries, wages, and fees payable | 1, 283, 709 | | | 0 | |
| 9.00 | Payroll taxes payable | 793, 542 | | 0 | 0 | |
| 0.00 | Notes and Loans payable (short term) | 818, 000 | | 0 | 0 | |
| 1.00 2.00 | Deferred income Accelerated payments | | | 0 | 0 | 4 |
| 3.00 | Due to other funds | |) c | 0 | 0 | |
| | Other current liabilities | 1, 022, 480 | | 0 | 0 | |
| | Total current liabilities (sum of lines 37 thru 44) | 15, 756, 798 | | | 0 | |
| | LONG TERM LI ABI LI TI ES | i | • | · · · · · | | 1 |
| 6.00 | Mortgage payable | C |) C | 0 | 0 | 40 |
| 7.00 | Notes payable | C |) C | 0 | 0 | 4 |
| 3.00 | Unsecured Loans | C |) C | 0 | 0 | |
| 9.00 | Other long term liabilities | 15, 391, 463 | | - | 0 | |
| D. 00 | Total long term liabilities (sum of lines 46 thru 49) | 15, 391, 463 | | | 0 | |
| I. 00 | Total liabilities (sum of lines 45 and 50) | 31, 148, 261 | C | 0 | 0 | 5 |
| 2.00 | CAPI TAL ACCOUNTS General fund balance | 12, 689, 087 | 1 | | | 5 |
| 2.00 3.00 | Specific purpose fund | 12,007,087 | | | | 5 |
| 1.00 | Donor created - endowment fund balance - restricted | | | 0 | | 5 |
| 5.00 | Donor created - endowment fund balance - unrestricted | | | 0 | | 5 |
| 5.00 | Governing body created - endowment fund balance | | | 0 | | 50 |
| 7.00 | Plant fund balance - invested in plant | | | | 0 | |
| B. 00 | Plant fund balance - reserve for plant improvement, | | | | 0 | 58 |
| | replacement, and expansion | | | | | |
| 9.00 | Total fund balances (sum of lines 52 thru 58) | 12, 689, 087 | | 0 | 0 | |
| 0.00 | Total liabilities and fund balances (sum of lines 51 and | 43, 837, 348 | SI C | u 0 | 0 | 60 |

| | | YETTE REGIONAL | | | | | u of Form CM | | 552-10 |
|---|---|----------------|---|-------------|---|--|---|-----|--|
| STATEN | IENT OF CHANGES IN FUND BALANCES | | Provider CC | CN: 15-0064 | | eriod: com 10/01/2017 0 09/30/2018 | Worksheet G Date/Time P 2/28/2019 1 | rep | ared: |
| | | General | Fund | Speci al | Pur | pose Fund | Endowment Fu | | pin |
| | | 1.00 | 0.00 | | | | 5.00 | | |
| 1.00 | Fund balances at beginning of period | 1.00 | 2.00 14,511,262 | 3.00 | | 4.00 | 5.00 | | 1.00 |
| 2.00 | Net income (loss) (from Wkst. G-3, line 29) | | -1, 793, 134 | | | Ű | | | 2.00 |
| 3.00 | Total (sum of line 1 and line 2) | | 12, 718, 128 | | ~ | 0 | | | 3.00 |
| 4.00 5.00 | Additions (credit adjustments) (specify) | 0 | | | 0 | | | 0 | 4.00 5.00 |
| 6.00 | | 0 | | | 0 | | | 0 | 6.00 |
| 7.00 | | 0 | | | 0 | | | 0 | 7.00 |
| 8.00 | | 0 | | | 0 | | | 0 | 8.00 |
| 9.00 10.00 | Total additions (sum of line 4-9) | 0 | 0 | | 0 | 0 | | - | 9.00 10.00 |
| 11.00 | Subtotal (line 3 plus line 10) | | 12, 718, 128 | | | 0 | | | 11.00 |
| 12.00 | Deductions (debit adjustments) (specify) | 0 | | | 0 | | | | 12.00 |
| 13.00 | | 0 | | | 0 | | | | 13.00 |
| 14.00 15.00 | | 0 | | | 0 | | | | 14.00 15.00 |
| 16.00 | | 0 | | | 0 | | | | 16.00 |
| 17.00 | | 0 | | | 0 | | | 0 | 17.00 |
| 18.00 | Total deductions (sum of lines 12-17) | | 0 | | | 0 | | | 18.00 |
| 19.00 | Fund balance at end of period per balance sheet (line 11 minus line 18) | | 12, 718, 128 | | | 0 | | | 19.00 |
| | | Endowment Fund | PI ant | Fund | | | | | |
| | | 6.00 | 7.00 | 8,00 | | | | | |
| 1.00 | Fund balances at beginning of period | | | | | | | _ | 1 00 |
| | | 0 | | | 0 | | | | 1.00 |
| 2.00 | Net income (loss) (from Wkst. G-3, line 29) | _ | | | | | | | 2.00 |
| 3.00 | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) | 0 | 0 | | 0 0 | | | | 2. 00 3. 00 |
| 3.00 4.00 | Net income (loss) (from Wkst. G-3, line 29) | _ | 0 0 | | | | | | 2.00 |
| 3.00 4.00 5.00 6.00 | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) | _ | - | | | | | | 2.00 3.00 4.00 5.00 6.00 |
| 3.00 4.00 5.00 6.00 7.00 | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) | _ | 0 0 0 | | | | | | 2.00 3.00 4.00 5.00 6.00 7.00 |
| 3.00 4.00 5.00 6.00 7.00 8.00 | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) | _ | 0 0 0 0 | | | | | | 2.00 3.00 4.00 5.00 6.00 7.00 8.00 |
| 3.00 4.00 5.00 6.00 7.00 8.00 9.00 | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) | _ | 0 0 0 | | | | | | 2.00 3.00 4.00 5.00 6.00 7.00 |
| 3.00 4.00 5.00 6.00 7.00 8.00 | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) | _ | 0 0 0 0 | | 0 | | | | 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 |
| $\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ \end{array}$ | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) | _ | 0 0 0 0 0 | | 0 | | | | $\begin{array}{c} 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00 \end{array}$ |
| $\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ \end{array}$ | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) | _ | 0 0 0 0 0 0 0 | | 0 | | | | $\begin{array}{c} 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00 \end{array}$ |
| $\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ \end{array}$ | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) | _ | 0 0 0 0 0 | | 0 | | | | $\begin{array}{c} 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00 \end{array}$ |
| $\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$ | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) | _ | 0 0 0 0 0 0 0 0 0 | | 0 | | | | $\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$ |
| $\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00 \end{array}$ | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) | 0 0 0 | | | 0 | | | | $\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 17.\ 00\\ \end{array}$ |
| $\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$ | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) | _ | | | 000000000000000000000000000000000000000 | | | | $\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$ |
| $\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00 \end{array}$ | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) | 0 0 0 | | | 0 | | | | $\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 17.\ 00\\ \end{array}$ |

| OT | | EALTH SYSTEM | | | | u of Form CMS-2 | |
|----------------|--|--------------|------------|-----|----------------------------|---|--------|
| STATEN | IENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider C | 1 | То | n 10/01/2017 09/30/2018 | Worksheet G-2 Parts I & II Date/Time Pre 2/28/2019 1:0 | pared: |
| | Cost Center Description | | Inpatient | | Outpatient | Total | |
| | PART I – PATIENT REVENUES | | 1.00 | | 2.00 | 3.00 | |
| | General Inpatient Routine Services | | | | | | |
| 1.00 | Hospi tal | | 5, 713, 7 | 00 | | 5, 713, 799 | 1.00 |
| 2.00 | SUBPROVIDER - IPF | | 312, 7 | | | 312, 778 | 2.00 |
| 3.00 | SUBPROVIDER - IRF | | 1,6 | | | 1, 605 | 3.00 |
| 4.00 | SUBPROVI DER | | 1,0 | 0 | | 0 | 4.00 |
| 5.00 | Swing bed - SNF | | | 0 | | 0 | 5.00 |
| 6.00 | Swing bed - NF | | | 0 | | 0 | 6.00 |
| 7.00 | SKILLED NURSING FACILITY | | | | | | 7.00 |
| 8.00 | NURSING FACILITY | | 1 | | | | 8.00 |
| 9.00 | OTHER LONG TERM CARE | | | | | | 9.00 |
| 10.00 | Total general inpatient care services (sum of lines 1-9) | | 6, 028, 1 | 82 | | 6, 028, 182 | 10.00 |
| | Intensive Care Type Inpatient Hospital Services | | | | | | |
| 11.00 | INTENSIVE CARE UNIT | | 1, 131, 2 | 255 | | 1, 131, 255 | |
| 12.00 | CORONARY CARE UNI T | | | | | | 12.00 |
| 13.00 | BURN INTENSIVE CARE UNIT | | | | | | 13.00 |
| 14.00 | SURGI CAL I NTENSI VE CARE UNI T | | | | | | 14.00 |
| 15.00 | OTHER SPECIAL CARE (SPECIFY) | . | 4 404 0 | | | 4 404 055 | 15.00 |
| 16.00 | Total intensive care type inpatient hospital services (sum of | riines | 1, 131, 2 | 55 | | 1, 131, 255 | 16.00 |
| 17.00 | 11-15) Total inpatient routine care services (sum of lines 10 and 10 | 5) | 7, 159, 4 | 27 | | 7, 159, 437 | 17.00 |
| 18.00 | Ancillary services |) | 7, 139, 4 | | 53, 684, 853 | 61, 566, 373 | 18.00 |
| 19.00 | Outpatient services | | 7, 881, 9 | | 19, 366, 381 | 20, 103, 845 | |
| 20.00 | RURAL HEALTH CLINIC | | , , , , , | 0 | 17, 300, 301 | 20, 103, 049 | 20.00 |
| 21.00 | FEDERALLY QUALIFIED HEALTH CENTER | | | 0 | 0 | 0 | 21.00 |
| 22.00 | HOME HEALTH AGENCY | | | - | ō | 0 | 22.00 |
| 23.00 | AMBULANCE SERVICES | | | 0 | 0 | 0 | 23.00 |
| 24.00 | СМНС | | | | | | 24.00 |
| 25.00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | | | 25.00 |
| 26.00 | HOSPI CE | | | 0 | 0 | 0 | 26.00 |
| 27.00 | OTHER NONREIMBURSABLE COST CENTERS | | 8, 479, 8 | 801 | -850, 939 | 7, 628, 862 | 27.00 |
| 27.01 | OTHER NONREIMBURSABLE COST CENTERS | | | 0 | 643, 573 | 643, 573 | |
| 27.02 | PROFESSIONAL FEES | | 305, 0 | | 6, 533, 325 | 6, 838, 420 | |
| 28.00 | Total patient revenues (sum of lines 17-27)(transfer column 3 | 3 to Wkst. | 24, 563, 3 | 17 | 79, 377, 193 | 103, 940, 510 | 28.00 |
| | G-3, line 1) | | | | | | |
| 29.00 | PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) | | | | 53, 325, 094 | | 29.00 |
| 29.00 30.00 | ADD (SPECIFY) | | | 0 | 55, 525, 094 | | 30.00 |
| 30.00 | ADD (SFECTIT) | | | 0 | | | 31.00 |
| 32.00 | | | | 0 | | | 32.00 |
| 33.00 | | | | 0 | | | 33.00 |
| 34.00 | | | | 0 | | | 34.00 |
| 35.00 | | | | 0 | | | 35.00 |
| 36.00 | Total additions (sum of lines 30-35) | | | | 0 | | 36.00 |
| 37.00 | DEDUCT (SPECI FY) | | | 0 | | | 37.00 |
| 38.00 | | | | 0 | | | 38.00 |
| 39.00 | | | | 0 | | | 39.00 |
| 40.00 | | | | 0 | | | 40.00 |
| 41.00 | | | | 0 | | | 41.00 |
| 42.00 | Total deductions (sum of lines 37-41) | | | | 0 | | 42.00 |
| 43.00 | Total operating expenses (sum of lines 29 and 36 minus line 4 | 12)(transfer | | | 53, 325, 094 | | 43.00 |
| | to Wkst. G-3, line 4) | | | 1 | | | |

| Heal th | Financial Systems | FAYETTE REGIONAL HE | ALTH SYSTEM | In Lie | u of Form CMS-2 | 2552-10 |
|----------------|---|--------------------------|-----------------------|---|---|----------------|
| STATEM | IENT OF REVENUES AND EXPENSES | | Provider CCN: 15-0064 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-3 Date/Time Prep 2/28/2019 1:02 | |
| | | | | | 1.00 | |
| 1.00 | Total patient revenues (from Wkst. G- | 2 Part L column 2 Lin | 29) | | 103, 940, 510 | 1.00 |
| 2.00 | Less contractual allowances and disco | | | | 65, 777, 325 | 2.00 |
| 3.00 | Net patient revenues (line 1 minus li | | 15 | | 38, 163, 185 | 2.00 |
| 4.00 | Less total operating expenses (from W | · | 13) | | 53, 325, 094 | 4.00 |
| 5.00 | Net income from service to patients (| | (3) | | -15, 161, 909 | 5.00 |
| 0.00 | OTHER I NCOME | | | | 10, 101, 707 | 0.00 |
| 6.00 | Contributions, donations, bequests, e | etc | | | 0 | 6.00 |
| 7.00 | Income from investments | | | | 0 | 7.00 |
| 8.00 | Revenues from telephone and other mis | cellaneous communication | servi ces | | 0 | 8.00 |
| 9.00 | Revenue from television and radio ser | vi ce | | | 0 | 9.00 |
| 10.00 | Purchase di scounts | | | | 0 | 10.00 |
| 11.00 | Rebates and refunds of expenses | | | | 0 | 11.00 |
| 12.00 | Parking lot receipts | | | | 0 | 12.00 |
| 13.00 | Revenue from Laundry and Linen servic | e | | | 0 | 13.00 |
| 14.00 | Revenue from meals sold to employees | and guests | | | 0 | 14.00 |
| 15.00 | Revenue from rental of living quarter | | | | 0 | 15.00 |
| 16.00 | Revenue from sale of medical and surg | | nan patients | | 0 | 16.00 |
| 17.00 | Revenue from sale of drugs to other t | | | | 0 | 17.00 |
| 18.00 | Revenue from sale of medical records | | | | 0 | 18.00 |
| 19.00 | Tuition (fees, sale of textbooks, uni | | | | 0 | 19.00 |
| 20.00 | Revenue from gifts, flowers, coffee s | hops, and canteen | | | 0 | 20.00 |
| 21.00 | Rental of vending machines | | | | 0 | 21.00 |
| 22.00 | Rental of hospital space | | | | 0 | 22.00 |
| 23.00 | Governmental appropriations | | | | 0 | 23.00 |
| 24.00 | OTHER OPERATING REVENUE | | | | 12, 769, 907 | |
| 24.01 | ADDI TI ONAL EXPENSE/REVENUE | | | | 556, 433 | |
| 24.02 | OTHER NON-OPERATING REVENUE | ` | | | 42, 435 | |
| 25.00 | Total other income (sum of lines 6-24 | .) | | | 13, 368, 775 | 25.00 |
| 26.00 27.00 | Total (line 5 plus line 25) OTHER EXPENSES (SPECIFY) | | | | -1, 793, 134 0 | 26.00 27.00 |
| 27.00 | Total other expenses (sum of line 27 | and subserints) | | | 0 | 27.00 |
| | Net income (or loss) for the period (| | | | -1, 793, 134 | |
| 27.00 | The come (or ross) for the period (| THE 20 III HUS THE 20) | | I | -1, 775, 154 | 27.00 |

| ALCULI | ATION OF CAPITAL PAYMENT | Provider CCN: 15-0064 | Period: From 10/01/2017 To 09/30/2018 | Worksheet L Parts I-III Date/Time Pre 2/28/2019 1:02 | |
|--------------|---|---------------------------------------|---|---|------|
| | | Title XVIII | Hospi tal | PPS | 2 pm |
| | | | | | |
| | | | | 1.00 | |
| | PART I - FULLY PROSPECTIVE METHOD | | | | - |
| 00 | CAPITAL FEDERAL AMOUNT Capital DRG other than outlier | | | 129, 530 | 1 1. |
| 00 | Model 4 BPCI Capital DRG other than outlier | | | 129, 550 | 1. |
| 00 | Capital DRG outlier payments | | | 1, 948 | |
| 01 | Model 4 BPCI Capital DRG outlier payments | | | 1, 740 | |
| 00 | Total inpatient days divided by number of days in the cost | reporting period (see inst | ructions) | 8.80 | |
| 00 | Number of interns & residents (see instructions) | · · · · · · · · · · · · · · · · · · · | | 0.00 | |
| 00 | Indirect medical education percentage (see instructions) | | | 0.00 | 5. |
| 00 | Indirect medical education adjustment (multiply line 5 by t | he sum of lines 1 and 1.01 | , columns 1 and | 0 | 6. |
| | 1.01) (see instructions) | | | | |
| 00 | Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions) | | , part A line | 0.00 | |
| 00 | Percentage of Medicaid patient days to total days (see inst | ructions) | | 0.00 | |
| | Sum of lines 7 and 8 | | | 0.00 | |
| | Allowable disproportionate share percentage (see instructio | ons) | | 0.00 | |
| 1 | Disproportionate share adjustment (see instructions) | | | 121 470 | 11. |
| . 00 | Total prospective capital payments (see instructions) | | | 131, 478 | 12. |
| | | | | 1.00 | |
| | PART II - PAYMENT UNDER REASONABLE COST | | | | |
| 00 | Program inpatient routine capital cost (see instructions) | | | 0 | 1. |
| 00 | Program inpatient ancillary capital cost (see instructions) | | | 0 | |
| 00 | Total inpatient program capital cost (line 1 plus line 2) | | | 0 | |
| 00 | Capital cost payment factor (see instructions) | | | 0 | |
| 00 | Total inpatient program capital cost (line 3 x line 4) | | | 0 | 5. |
| | | | | 1.00 | |
| | PART III - COMPUTATION OF EXCEPTION PAYMENTS | | | | |
| 00 | Program inpatient capital costs (see instructions) | | | 0 | |
| 00 | Program inpatient capital costs for extraordinary circumsta | nces (see instructions) | | 0 | |
| 00 | Net program inpatient capital costs (line 1 minus line 2) | | | 0 | - |
| 00 | Applicable exception percentage (see instructions) | | | 0.00 | |
| 00 | Capital cost for comparison to payments (line 3 x line 4) | i notruoti enc) | | 0 | - |
| 00 00 | Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina | - | lino (| 0.00 | |
| 00 | Capital minimum payment level (line 5 plus line 7) | ing cricullistances (iffle 2 x | | 0 | |
| 00 | Current year capital payments (from Part I, line 12, as app | licable) | | 0 | - |
| | Current year comparison of capital minimum payment level to | | less line 9) | 0 | |
| | Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) | | , | 0 | |
| . 00 | Net comparison of capital minimum payment level to capital | payments (line 10 plus lin | e 11) | 0 | 12. |
| | Current year exception payment (if line 12 is positive, ent | | | 0 | 13. |
| | Carryover of accumulated capital minimum payment level over | | | 0 | 14 |
| | | | | | 1 |
| 1.00 | (if line 12 is negative, enter the amount on this line) | | | | |
| 1.00 5.00 | | | | 0 | |