This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-1346 Worksheet S Peri od: From 07/01/2022 Parts I-III AND SETTLEMENT SUMMARY 06/30/2023 Date/Time Prepared: 11/29/2023 3:06 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 11/29/2023 Ti me: 3:06 pm] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FAYETTE COUNTY HOSPITAL (14-1346) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Karen Dyer		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Karen Dyer			2
3	Signatory Title	CEO CEO			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	479, 288	-938, 952	0	56, 227	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	564, 954	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
10.00	RURAL HEALTH CLINIC I	0		-119, 669		0	10.00
10. 01	RURAL HEALTH CLINIC II	0		-40, 962		0	10.01
200.00	TOTAL	0	1, 044, 242	-1, 099, 583	0	56, 227	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems FAYETTE COMPLEX IDENTIFICATION DATA FAYETTE COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Peri od: Worksheet S-2
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 11/29/2023 3: 06 pm Provi der CCN: 14-1346

	1.00		2. 00		3. 00			4	4. 00			
	Hospital and Hospital Health Care Co	omplex Ad	dress:									
1.00	Street: SEVENTH & TAYLOR		PO Box:									1.00
2.00	City: VANDALIA	_	State: IL	Zip Cod				y: FAYETTE	1-			2.00
		Comp	oonent Name	CCN	CBS		vi der	Date		nt Syst		
				Number	Numb	ber I	јуре	Certi fi ed		0, or		-
			1. 00	2.00	3. (00 4	1. 00	5. 00	V 6. 00	7. 00	XI X 8. 00	
	Hospital and Hospital-Based Componer	nt Identi		2.00	3. (00 4	r. 00	5.00	0.00	7.00	0.00	
3. 00	Hospi tal		COUNTY HOSPITAL	141346	999	914	1	04/01/2005	N	0	0	3.00
4. 00	Subprovi der - IPF			1			•	0 17 0 17 2000	''			4.00
5.00	Subprovi der - IRF										İ	5.00
6.00	Subprovi der - (Other)											6.00
7.00	Swing Beds - SNF	FAYETTE	COUNTY SNF	14Z346	999	914		04/01/2005	N	0	N	7.00
8. 00	Swing Beds - NF											8.00
9. 00	Hospi tal -Based SNF	FAYETTE	COUNTY SNF	145499	999	914		07/01/1983	N	P	0	9.00
10.00	Hospital -Based NF											10.00
11. 00 12. 00	Hospital Based OLTC											11.00
13. 00	Hospi tal -Based HHA Separately Certified ASC				-							13.00
14. 00	Hospi tal -Based Hospi ce											14.00
15. 00	Hospital -Based Health Clinic - RHC	VANDALI A		148527	999	914		06/01/2013	N	0	N	15. 00
15. 01		ST ELMO		148528	999			06/01/2013		0	N	15. 01
									''			
16.00	Hospital-Based Health Clinic - FQHC											16.00
17. 00	Hospital-Based (CMHC) I											17. 00
18. 00	Renal Dialysis											18. 00
19. 00	Other											19.00
								From: 1.00		To		
2000	Cost Reporting Period (mm/dd/yyyy)							07/01/2		06/30/		20.00
	Type of Control (see instructions)							2	022	00/ 30/	2023	21.00
	1.7 1							_				
						1.	00	2. 00		3. 0	00	
	Inpatient PPS Information							1				
22. 00	Does this facility qualify and is it					N	N.	N				22. 00
	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo				K							
	facility subject to 42 CFR Section §											
	hospital?) In column 2, enter "Y" for			CHamerre								
22. 01	Did this hospital receive interim UC			ital UCPs,	for	l 1	V	N				22. 01
	this cost reporting period? Enter in	n column	1, "Y" for yes	or "N" fo	r no							
	for the portion of the cost reportir											
	1. Enter in column 2, "Y" for yes or				he							
	cost reporting period occurring on o	or after (October 1. (see	•								
22. 02	instructions) Is this a newly merged hospital that	t require	s a final IICD t	n ha			J	N				22. 02
22.02	determined at cost report settlement				Lumn	'	V	IN IN				22.02
	1, "Y" for yes or "N" for no, for the				1 dilli 1							
	period prior to October 1. Enter in				no,							
	for the portion of the cost reportir											
22. 03	Did this hospital receive a geograph					l N	J	N		N		22. 03
	rural as a result of the OMB standar											
	adopted by CMS in FY2015? Enter in of the portion of the cost reportir											
	in column 2, "Y" for yes or "N" for				eı							
	reporting period occurring on or aft											
	Does this hospital contain at least											
	counted in accordance with 42 CFR 41	12. 105)?	Enter in column	1 3, "Y" f	or							
	yes or "N" for no.											
22. 04	Did this hospital receive a geograph											22. 04
	rural as a result of the revised OME											
	adopted by CMS in FY 2021? Enter in for the portion of the cost reportir											
	in column 2, "Y" for yes or "N" for				CI							
	reporting period occurring on or aft											
	Does this hospital contain at least											
	counted in accordance with 42 CFR 41											
	yes or "N" for no.											
23. 00	Which method is used to determine Me below? In column 1, enter 1 if date							2 N				23. 00

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost

reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems FAYETTE COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1346 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/29/2023 3: 06 pm | XVIII | XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 58.00 Pt. I 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4. 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61 02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 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 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	FAYETT	E COUNTY HOSPITAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provi der CC		eriod: fom 07/01/2022 o 06/30/2023	Worksheet S-2 Part I Date/Time Pre 11/29/2023 3:0	pared:
			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der	Hospi tal	col . 2))	
			Si te 1.00	2. 00	3. 00	
Section 5504 of the ACA Base Yea	ar FTE Residents in N	onprovider Settings				
period that begins on or after of the following seriod that begins on or after of the following seriod the first seriod that the following seriod th	0.00	0.00	0. 000000	64.00		
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
			Si te	поэрг саг	COI . 47)	
(F 00 Fatar in advant 1 if line (2	1. 00	2. 00	3. 00	4. 00	5. 00	/F 00
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)			0.00	0.00		65. 00
			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der	Hospi tal	col . 2))	
			Si te	2.00	2.00	
Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Setting	1.00 sEffective f	2.00 or cost report	3.00 ing periods	
beginning on or after July 1, 20			,		0 .	
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 divided by (column 1 divided by (column 1 divided by	occurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of structions)	0.00	0. 00	0. 000000	66.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
67.00 Enter in column 1, the program	1. 00	2. 00	3.00	4. 00 0. 00	5. 00 0. 000000	67.00
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0.00000	· · · · · · · · · · · · · · · · · · ·

	Financial Systems FAYETTE COUNTY HOSPITAL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC		Peri od:	eu of Form CMS Worksheet S-	
			From 07/01/202 To 06/30/202		
				1.00	_
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-490 For a cost reporting period beginning prior to October 1, 2022, did you obtained to apply the new DGME formula in accordance with the FY 2023 IPPS Final (August 10, 2022)?	otain permiss	ion from your	N	68. 00
	I posti ent Deveki etri e Feelli tu DDC		1.	00 2.00 3.00)
70. 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it conta Enter "Y" for yes or "N" for no.	ain an IPF su	bprovi der?	N	70.00
	If line 70 is yes: Column 1: Did the facility have an approved GME teachir recent cost report filed on or before November 15, 2004? Enter "Y" for year 2 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for year 2 Column 3: If column 2 is Y, indicate which program year began during this (see instructions) Inpatient Rehabilitation Facility PPS	es or "N" for in a new tea es or "N" for	no. (see chi ng no.	0	71.00
75. 00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it co	ontain an IRF		N	75. 00
	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teachir recent cost reporting period ending on or before November 15, 2004? Enter no. Column 2: Did this facility train residents in a new teaching program CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If indicate which program year began during this cost reporting period. (see	"Y" for yes in accordanc column 2 is	or "N" for e with 42 Y,	0	76. 00
				1.00	
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for r is this a LTCH co-located within another hospital for part or all of the c"Y" for yes and "N" for no.		g period? Ente	N er N	80. 00 81. 00
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter Did this facility establish a new Other subprovider (excluded unit) under			D. N	85. 00 86. 00
87. 00	\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified to 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	under section		N	87.00
			Approved fo Permanent Adjustment (Y/N) 1.00	Approved	
	Column 1: Is this hospital approved for a permanent adjustment to the TEFF amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete		е		0 88.00
	Column 2: Enter the number of approved permanent adjustments.	Wkst. A Line	e Effective	Approved	
		No.	Date	Permanent Adjustment Amount Per Discharge	
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2. 00	3.00	0 89.00
07.00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.	0. 0			0, 07, 00
	Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.				
			1. 00	2. 00	
90. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Er yes or "N" for no in the applicable column.	nter "Y" for	N	Y	90.00
91. 00	yes of N for no fit the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00
92. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual certificati instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
	Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column.		N	Y	93. 00
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no applicable column.		N	N	94.00
	If line 94 is "Y", enter the reduction percentage in the applicable column Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no		0. 00 N	0. 00 N	95. 00 96. 00
70.00	applicable column.				

Health Financial Systems FAYETTE COUN	TY HOSPITAL		In lie	u of Form CM:	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 14-1346	Peri od: From 07/01/2022 To 06/30/2023	Worksheet S Part I Date/Time P	6-2 Prepared:
			V	11/29/2023 XI X	3: 06 pm
	<u> </u>		1.00	2.00	
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" column 1 for title V, and in column 2 for title XIX.			N	N	98. 00
98.01 Does title V or XIX follow Medicare (title XVIII) for the IC, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.				N	98. 01
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 for title V, and in column 2 for title XIX.			N	Y	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.				Y	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAP outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.		N N	Y	98. 04	
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 column 2 for title XIX.				N	98. 05
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 colur column 2 for title XIX.			N	Y	98. 06
Rural Providers					
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all	-inclusive met	thod of payme	nt Y		105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for a training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded I	nn 1. (see ins o you train I&F	structions) Rs in an	N		107. 00
Enter "Y" for yes or "N" for no in column 2. (see instruction 108.00 st this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	tions)		2 N		108. 00
[51.1. 33321 611] T121 T13(6), Enter	Physi cal	Occupati ona		Respi rator	У
109.00 f this hospital qualifies as a CAH or a cost provider, are	1.00	2. 00 N	3. 00 N	4. 00 N	109. 00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			, N	14	107.00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospital 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.	If yes,	N N	110.00
			1.00	2. 00	
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to of integration prong of the FCHIP demo in which this CAH is particle all that apply: "A" for Ambulance services; "B" for a for tele-health services.	cost reporting column 1 is Y, articipating ir	period? Ente enter the n column 2.	N	2. 00	111.00
		1.00	2. 00	3. 00	
112.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost is period? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital comparticipation in the demonstration, if applicable.	reporting column 1 is pating in the	N	2. 00	0.00	112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide	B, or E only) '93" percent (i ncl udes	N			0115.00
the definition in CMS Pub.15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116. 00
117.00 Is this facility legally-required to carry malpractice insu	urance? Enter	N			117. 00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence point if the policy is claim-made. Enter 2 if the policy is occur			1		118. 00

Health Financial Systems	FAYETTE COUNTY	HOSPI TAL		In Lie	u of Form CN	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE		Provi der CC	CN: 14-1346	Peri od: From 07/01/2022 To 06/30/2023	Worksheet S Part I Date/Time I	S-2 Prepared:
			Premi ums	Losses	11/29/2023 Insurance	
118.01 List amounts of malpractice premiums ar	nd paid Losses:		1.00 2,397,0	2. 00	3.00	0118.01
				1.00	2.00	
118.02 Are malpractice premiums and paid losse				1. 00 N	2.00	118. 02
Administrative and General? If yes, su and amounts contained therein.	ubmit supporting schedu	le listing c	ost centers			
119.00 DO NOT USE THIS LINE						119. 00
120.00 Is this a SCH or EACH that qualifies for §3121 and applicable amendments? (see i					N	120. 00
"N" for no. Is this a rural hospital wi	th < 100 beds that qua	ulifies for t	he Outpatien			
Hold Harmless provision in ACA §3121 ar Enter in column 2, "Y" for yes or "N" 1		s? (see inst	ructions)			
121.00 Did this facility incur and report cost	ts for high cost implan	ntable device	s charged to	Y		121. 00
patients? Enter "Y" for yes or "N" for 122.00 Does the cost report contain healthcare		ned in §1903	(w)(3) of th	e Y	44. 00	122. 00
Act?Enter "Y" for yes or "N" for no in the Worksheet A line number where these		is "Y", ente	r in column	2		
123.00 Did the facility and/or its subprovider	rs (if applicable) purc					123. 00
services, e.g., legal, accounting, tax management/consulting services, from ar	preparation, bookkeepi n uprelated organizatio	ng, payroll, on? In column	and/or 1 enter "Y			
for yes or "N" for no.	_					
If column 1 is "Y", were the majority of professional services expenses, for ser				1		
located in a CBSA outside of the main h	nospital CBSA? In colum	nn 2, enter "	Y" for yes o	r		
"N" for no. Certified Transplant Center Information	า					
125.00 Does this facility operate a Medicare-o			"Y" for yes	N		125. 00
126.00 If this is a Medicare-certified kidney	transplant program, en	iter the cert	ification da	te		126. 00
in column 1 and termination date, if ap 127.00 If this is a Medicare-certified heart 1	•		fication dat	e		127. 00
in column 1 and termination date, if ap	oplicable, in column 2.					
128.00 If this is a Medicare-certified liver 1 in column 1 and termination date, if a			fication dat	e		128. 00
129.00 If this is a Medicare-certified lung to			ication date			129. 00
in column 1 and termination date, if ap 130.00 If this is a Medicare-certified pancrea			rti fi cati on			130. 00
date in column 1 and termination date, 131.00 If this is a Medicare-certified intesti			certi fi cati o	n		131. 00
date in column 1 and termination date,	if applicable, in colu	ımn 2.				
132.00 If this is a Medicare-certified islet to in column 1 and termination date, if and			fication dat	e		132. 00
133.00 Removed and reserved	•		h - ODOh -	_		133.00
134.00 If this is a hospital-based organ procuin column 1 and termination date, if a		po), enter ti	ne upu numbe	I		134. 00
All Providers 140.00 Are there any related organization or h	nome office costs as de	afined in CMS	Dub 15_1	Y	I	140. 00
chapter 10? Enter "Y" for yes or "N" for	or no in column 1. If y	es, and home	office cost	•		140.00
are claimed, enter in column 2 the home	e office chain number. 2.00	(see instruc	tions)	3. 00		
If this facility is part of a chain or	ganization, enter on li		ough 143 the		of the home	е
office and enter the home office contra 141.00 Name:	Contractor's Name:	tor number.	Contract	or's Number:		141. 00
	PO Box: State:		Zi p Code			142. 00 143. 00
145. 00 01 ty.	State.		Zi p code			143.00
144.00 Are provider based physicians' costs in	ncluded in Worksheet A?)			1. 00 Y	144. 00
TITI OOM O BI OVI dei Basea Bilysi erans Gosts II	ier daed 111 wer keneet 71.					111.00
145.00 If costs for renal services are claimed	d on Wkst. A. line 74	are the cost	s for	1.00	2.00	145. 00
inpatient services only? Enter "Y" for	yes or "N" for no in o	olumn 1. If	column 1 is			
no, does the dialysis facility include period? Enter "Y" for yes or "N" for r		or this cost	reporting			
146.00 Has the cost allocation methodology cha Enter "Y" for yes or "N" for no in colu	anged from the previous			F N		146. 00
yes, enter the approval date (mm/dd/yyy		, <u>z, cnapter</u> ,	10, 34020) I	.		

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLI		OUNTY HOSPITAL	CCN: 14-1346	Peri oc		u of Form CMS- Worksheet S-	
HUSPITAL AND HUSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DATA	Provi dei	CCN: 14-1346	From ()7/01/2022)6/30/2023	Part I	epared:
				·		1.00	
147.00 Was there a change in the statist	ical basis? Enter "Y"	for ves or "N" f	or no			1.00 N	147.0
148.00Was there a change in the order o						N N	148. 0
149.00 Was there a change to the simplif				for no.		N	149.0
	-	Part A	Part E	3	Title V	Title XIX	
		1. 00	2. 00		3. 00	4. 00	
Does this facility contain a prov							
or charges? Enter "Y" for yes or	"N" for no for each co			B. (See			4.55
155.00 Hospi tal		N	N N		N	N	155.0
I56.00 Subprovi der - IPF		N	N		N	N	156.0
57.00 Subprovider - IRF 58.00 SUBPROVIDER		N	N	-	N	N	157. C
158. 00 SUBPROVI DER 159. 00 SNF		N	l N		N	N	159.0
160.00 HOME HEALTH AGENCY		N N	N		N	N N	160. 0
161. 00 CMHC			l N		N	N N	161.0
							1
						1.00	
Mul ti campus							
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has	s one or more ca	mpuses in di	fferent (CBSAs?	N	165. 0
, , , , , , , , , , , , , , , , , , , ,	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						0.0	0166.0
column 5 (see instructions)						1.00	
Health Information Technology (HI	T) incentive in the Am	eri can Recovery	and Rei nvest	ment Act			
167.00 s this provider a meaningful use						Υ	167. 0
68.00 If this provider is a CAH (line 1			ine 167 is "	Y"), ente	er the		168. 0
reasonable cost incurred for the							1.00
168.01 If this provider is a CAH and is					rdshi p		168.0
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful transition factor. (see instructi	user (line 167 is "Y")				enter the	0.0	00169. C
in and their rector. (See Tristreet	oo,			Be	egi nni ng	Endi ng	
					1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and end	ng date for the	reporting				170. C
					1. 00	2. 00	
171.00 f ine 167 is "Y", does this pro	vider have any days for	r individuals en	rolled in		N N		0171. C
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, umn 1. If column 1 is y	Pt. I, line 2,	col. 6? Ente				1,1.0

	Financial Systems FAYETTE COUNTAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 14-1346	Period:	u of Form CMS- Worksheet S-2	
JJFII	AL AND HOSPITAL HEALTH CARE REINBURSEMENT QUESTIONWAIRE	FIOVIDE		From 07/01/2022 To 06/30/2023	Part II Date/Time Pro	epared:
	_			Y/N	11/29/2023 3: Date	:06 pm
				1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURS General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in	the	
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to th reporting period? If yes, enter the date of the change in			Y	07/01/2022	1.00
	reporting period? IT yes, enter the date of the change IT	corullir 2. (See	Y/N	Date	V/I	
			1. 00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in coluvoluntary or "I" for involuntary.	mn 3, "V" for	N			2.00
00	Is the provider involved in business transactions, includicontracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the proviofficers, medical staff, management personnel, or members of directors through ownership, control, or family and oth relationships? (see instructions)	offices, drug der or its of the board	N			3.00
			Y/N 1.00	Type 2. 00	Date 3.00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av column 3. (see instructions) If no, see instructions.	for Compiled,	Y	С		4.00
00	Are the cost report total expenses and total revenues diff those on the filed financial statements? If yes, submit re		N			5.00
	these on the fired framework of the josephanic for			Y/N	Legal Oper.	
				1. 00	2. 00	
00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	2: If yes, i	s the provide	r N		6.00
00	Are costs claimed for Allied Health Programs? If "Y" see i			N		7.00
00	Were nursing programs and/or allied health programs approv cost reporting period? If yes, see instructions.		Ü			8.00
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	ns.				9.00
. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.			N		10.00
. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved	N		11.00
					Y/N 1. 00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If ye	s, see instruc	tions.		Y	12.00
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.		-		N	13.00
	If line 12 is yes, were patient deductibles and/or coinsur instructions.	ance amounts w	aived? If yes	, see	N	14.00
	Bed Complement Did total beds available change from the prior cost report		yes, see ins		N N	15.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
00	PS&R Data Was the cost report prepared using the PS&R Report only?	l N		N		16.00
00	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	IN		IN		10.00
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 in columns 2 and 4. (see instructions)	Y	10/05/2023	Y	10/05/2023	17.00
00	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	N		N		18.00
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 information? If yes, see instructions.	N		N		19.00

LUCDIT	FAYETTE COUNT TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CNI: 14 1246	Period:	u of Form CMS Worksheet S	
HUSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN. 14-1340	From 07/01/2022 To 06/30/2023	Part II	repared:
		Descri	ipti on	Y/N	Y/N	3. 00 piii
)	1.00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	-	Y/N	Date	Y/N	Date	
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2. 00	3. 00 N	4. 00	21.00
21.00	records? If yes, see instructions.	IN		IN IN		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS I	HOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22.00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	N	23.00			
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	· ·			N	24.00
25. 00	Have there been new capitalized leases entered into during	the cost repo	rting period	? If yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	ne cost report	ing period?	If yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	cost reporti	ng period? I	f yes, submit	N	27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	ntered into du	ring the cos	t reporting	N	28.00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds (D	ebt Service	Reserve Fund)	N	29.00
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If ye	s, see	N	30.00
31. 00	instructions. Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser	rvi ces furni sh	ed through c	ontractual	N	32.00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to compet	itive bidding? If	N	33.00
	Provi der-Based Physi ci ans					
34.00	Were services furnished at the provider facility under an a	rrangement wi	th provider-	based physicians?	· Y	34.00
	If yes, see instructions.	Ü	·	. ,	N	35.00
	physicians during the cost reporting period? If yes, see in	stručti ons.				
				Y/N	Date	
	Home Offi on Conta			1.00	2. 00	
36 00	Home Office Costs Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been pr	epared by the	home office			37.00
	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off	, ,				38.00
	the provider? If yes, enter in column 2 the fiscal year end	of the home	offi ce.			39.00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	•	,			40.00
	instructions.		J 2, 222			
		1.	00	2.	00	
	Cost Report Preparer Contact Information					
41. 00	held by the cost report preparer in columns 1, 2, and 3,	JODI		SANDERS		41.00
	respectively. Enter the employer/company name of the cost report	BLUE & COMPANY		42.00		
42. 00	preparer.	DEUL & COMITAIN				.2.00

Health Financial Sy	ystems	FAYETTE COUNT	TY HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provi der	CCN: 14-1346	Peri od: From 07/01/2022	Worksheet S-2 Part II		
					To 06/30/2023	Date/Time Pre 11/29/2023 3:		
			·					
				3. 00				
Cost Report	Preparer Contact Information							
41.00 Enter the fi	rst name, last name and the	title/position	MANAGER				41.00	
held by the	cost report preparer in colu	ımns 1, 2, and 3,						
respectively	<i>[</i> .							
42.00 Enter the er	nployer/company name of the o	cost report					42.00	
preparer.								
	elephone number and email add						43.00	
report prepa	arer in columns 1 and 2, resp	ecti vel y.						

Health Financial Systems FAYETTE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 14-1346

						To 06/30/2023		
							I/P Days /	р
							0/P Visits /	
							Tri ps	
	Component	Worksheet A Line No.	No	. of Beds	Bed Days Available	CAH/REH Hours	Title V	
		1. 00		2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA	00.00		0.5				
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 12	29, 832. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)							
2. 00	HMO and other (see instructions)							2.00
3. 00	HMO IPF Subprovider							3.00
4. 00	HMO IRF Subprovider							4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						Ö	6.00
7. 00	Total Adults and Peds. (exclude observation			25	9, 12!	29, 832. 00	Ö	7. 00
7.00	beds) (see instructions)			20	,, 12	27,002.00	o l	7.00
8. 00	INTENSIVE CARE UNIT	31. 00		0		0.00	0	8. 00
9. 00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14.00	Total (see instructions)			25	9, 12	29, 832. 00	0	14.00
15.00	CAH visits						0	15.00
15. 10	REH hours and visits							15. 10
16.00	SUBPROVIDER - IPF							16.00
17.00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY	44. 00		85	31, 02	5	0	19. 00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC	00.00						25.00
26.00	RURAL HEALTH CLINIC	88. 00					0	26.00
26. 01	RURAL HEALTH CLINIC II	88. 01					0	26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		440			0	26. 25
27. 00	Total (sum of lines 14-26)			110			0	27. 00
28. 00 29. 00	Observation Bed Days						U	28. 00 29. 00
30.00	Ambul ance Trips							30.00
31.00	Employee discount days (see instruction) Employee discount days - IRF							30.00
32. 00	Labor & delivery days (see instructions)			0	(32.00
32. 00	Total ancillary labor & delivery room			U	,			32.00
JZ. U1	outpatient days (see instructions)							32.01
33. 00	LTCH non-covered days	}						33. 00
33. 01	LTCH site neutral days and discharges							33. 01
	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0			0	
			•	- 1	•	'	- 1	•

Peri od: Worksheet S-3 From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared: 11/29/2023 3:06 pm

						11/29/2023 3:	06 pm
		I/P Days	/ O/P Visits	/ Tri ps	Full Time E	Equi val ents	
			TI 11 VIV				
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		/ 00	7.00	Pati ents	& Residents	Payrol I	
	DADT I CTATICTICAL DATA	6. 00	7. 00	8. 00	9. 00	10.00	
1 00	PART I - STATISTICAL DATA	(01	0	1 242			1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	691	9	1, 243			1.00
	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	114	92				2.00
3. 00	HMO IPF Subprovi der	0	0				3.00
4. 00	HMO IRF Subprovider		Ö				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	820	Ö	820			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	020	0	330			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 511	9	2, 393			7.00
7.00	beds) (see instructions)	.,	i	2,070			7.00
8.00	INTENSIVE CARE UNIT	o	0	O			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1, 511	9	2, 393	0.00	163. 42	14.00
15.00	CAH visits	0	0	0			15. 00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0	5, 938	10, 795	0. 00	28. 28	
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE			_			24.00
24. 10	HOSPICE (non-distinct part)			O			24. 10
25. 00	CMHC - CMHC	4 400	4 470	40 500	0.00	0.54	25.00
26.00	RURAL HEALTH CLINIC	1, 499	4, 179	10, 529			
26. 01	RURAL HEALTH CLINIC II	262	482	1, 208		l e	26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00 28. 00	Total (sum of lines 14-26)		85 85	E 2.7	0. 00	203. 25	27. 00 28. 00
28.00	Observation Bed Days	0	85	527			29.00
30.00	Ambulance Trips Employee discount days (see instruction)	٥		O			30.00
31.00	Employee discount days (see Fristruction)			0			31.00
32. 00	Labor & delivery days (see instructions)	٥	0	0			32.00
32. 00	Total ancillary labor & delivery room	١	U U	0			32.00
JZ. U1	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days	o					33.00
	LTCH site neutral days and discharges						33.01
	Temporary Expansion COVID-19 PHE Acute Care		0	0			34.00
2 30	1 - 1 - 3	١	٥	,	1	1	

| Peri od: | Worksheet S-3 | From 07/01/2022 | Part | To 06/30/2023 | Date/Time Prepared: Provider CCN: 14-1346

				To	06/30/2023	Date/Time Pre 11/29/2023 3:0	
		Full Time		Di sch	arges	11/29/2023 3.	oo piii
		Equi val ents		D1 3011	ai ges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	'	Workers				Pati ents	
		11. 00	12. 00	13. 00	14.00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	159	3	375	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			25	24		2.00
3. 00	HMO IPF Subprovi der				0		3.00
4. 00	HMO IRF Subprovi der				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0 00
8. 00	I NTENSI VE CARE UNI T						8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY						12. 00 13. 00
14. 00	Total (see instructions)	0.00	0	159	3	375	14.00
15. 00	CAH visits	0.00	0	159	3	375	15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0.00					19.00
20. 00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC	0.00					26.00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	,	0.00					27.00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00							32.00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days			o			33. 00
33. 00	LTCH non-covered days LTCH site neutral days and discharges						33. 00
	Temporary Expansi on COVID-19 PHE Acute Care						34. 00
5 1. 00	1. Simpo. ar y Expansion Sourb 17 The house date	ı		1	ļ		31.00

Heal th	n Financial Systems	FAYETTE COUN	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI 1	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1346	Peri od:	Worksheet S-8	3
			Component	CCN: 14-8527	From 07/01/2022 To 06/30/2023		
					RHC I	Cost	
					1	00	4
	Clinic Address and Identification				1.	00	
1.00	Street				1442 N 8TH STR	EET, SUITE C	1.00
				ty	State	ZIP Code	
2 00	City, State, ZIP Code, County		VANDALI A	00	2.00	3. 00 62471	2.00
2. 00	City, State, ZIP code, county		IVANDALI A			02471	2.00
						1. 00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for run	al or "U" for			0	3.00
					nt Award 1.00	Date 2.00	
	Source of Federal Funds			1	1.00	2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6. 00 7. 00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	10(d), PHS Act)					6. 00 7. 00
8. 00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9.00
				•			
10.00	Dana this facility and the ather than a	: 4-1 11	DUC FOUCO F	"\/"	1.00	2.00	10.00
10.00	Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of	other operatio	ns in column		0	10.00
	Tiour S. J	Sur	nday	T	londay	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1)		I	07: 00	17: 00	07: 00	11.00
11.00	CLINIC			07.00	17.00	07.00	11.00
					1. 00	2. 00	
12. 00 13. 00		ed in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N N	0	12.00 13.00
				Prov	ider name	CCN	
11.00	DUO (FOUO				1. 00	2. 00	44.04
14.00	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visits	14.00
		1. 00	2.00	3.00	4.00	5. 00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
				ınty			
2.00	City Chata 71D Cada Const			00			0.00
2. 00	City, State, ZIP Code, County	Tuesday	FAYETTE Wedn	esday	Thur	sday	2.00
		to	from	to	from	to	
		6. 00	7. 00	8.00	9. 00	10.00	
	Facility hours of operations (1)	1	1				
11. 00	CLINIC	17: 00	07: 00	17: 00	07: 00	17: 00	11.00

Health Financial Systems	FAYETTE COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 14-1346	Peri od:	Worksheet S-8	
		Component	CCN: 14-8527	From 07/01/2022 To 06/30/2023	Date/Time Pre	
				RHC I	11/29/2023 3: Cost	06 pm
			1		0031	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	12: 00				11. 00

Heal th	n Financial Systems	FAYETTE COUN	TY HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1346	Peri od:	Worksheet S-8	8
			Component	CCN: 14-8528	From 07/01/2022 To 06/30/2023		
					RHC II	Cost	
					1	00	-
	Clinic Address and Identification				1.	00	
1.00	Street		1		428 N MAIN STR		1.00
				ty	State	ZIP Code	
2. 00	City, State, ZIP Code, County		SAINT ELMO	00	2.00	3. 00 62458	2.00
2.00	city, State, ZIP code, county	-	SATIVI ELIVIO			02436	2.00
	T					1. 00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for run	al or "U" for			C	3.00
					nt Award 1.00	2. 00	
	Source of Federal Funds				1.00	2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6. 00	Health Services for the Homeless (Section 34	O(d), PHS Act)					6.00
7.00	Appal achi an Regi onal Commission						7.00
8. 00 9. 00	Look-Alikes OTHER (SPECIFY)						8. 00 9. 00
7.00	OTHER (SI ECT 1)						7.00
					1. 00	2. 00	
10.00	3 1					C	10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type of hours.)	of other operat	ion(s) and the	operating			
	Tiour S.)	Sun	day	Ι	l Nonday	Tuesday	
		from	to	from	to	from	
		1. 00	2.00	3.00	4.00	5. 00	
	Facility hours of operations (1)				1.2.2	l	
11. 00	CLINIC			08: 00	12: 00	08: 00	11.00
					1. 00	2. 00	
12. 00	Have you received an approval for an excepti	on to the prod	uctivity stand	ard?	N	2100	12.00
13.00					N	C	13.00
	30.8? Enter "Y" for yes or "N" for no in col						
	number of providers included in this report.	List the name	s of all provi	ders and			
	numbers below.			Prov	ider name	CCN	
				1.00	1. 00	2. 00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N	V	XVIII	XIX	Total Visits	
45.00	The same of the body of the body of the same of the body of the bo	1. 00	2. 00	3. 00	4. 00	5. 00	45.00
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15.00
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)		Col	l Inty			
				00			
2.00	City, State, ZIP Code, County		FAYETTE				2.00
		Tuesday		esday		sday	
		to	from	to	from	to	
	Facility hours of operations (1)	6. 00	7. 00	8. 00	9. 00	10.00	
11 00	CLINIC	12: 00	13: 00	17: 00	08: 00	12: 00	11.00
	JOETHIO	112.00	110.00	1.7.00	00.00	112.00	1 11.00

Health Financial Systems	FAYETTE COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	}
		Component		From 07/01/2022 To 06/30/2023		
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC						11. 00

Hoal +h	Financial Systems	FAYETTE COUNTY	HUCDI TAI		In Lio	u of Form CMS 1)EE2 10
	Financial Systems AL UNCOMPENSATED AND INDIGENT CARE DATA	PATELLE COUNTY	Provi der CO	:N: 14-1346	Peri od:	u of Form CMS-2 Worksheet S-1	
1103111	AE ONOOMI ENSATED AND THUTGENT GARE DATA		l rovider ee	SN. 14 1540	From 07/01/2022	Worksheet 5 1	O
					To 06/30/2023		
						11/29/2023 3:	oo piii
						1. 00	
	Uncompensated and indigent care cost computa						
1.00	Cost to charge ratio (Worksheet C, Part I Ii	ne 202 column 3 d	livided by li	ne 202 colum	n 8)	0. 375168	1. 00
2 00	Medicaid (see instructions for each line)					2 705 475	2.00
2. 00 3. 00	Net revenue from Medicaid Did you receive DSH or supplemental payments	from Modicaid?				3, 785, 475 Y	2. 00 3. 00
4. 00	If line 3 is yes, does line 2 include all DS		ental navment	ts from Medic	ai d2	N	4. 00
5. 00	If line 4 is no, then enter DSH and/or suppl				ara.	1, 318, 363	5. 00
6.00	Medi cai d charges	1.3				25, 660, 416	
7.00	Medicaid cost (line 1 times line 6)					9, 626, 967	7.00
8.00	Difference between net revenue and costs for	Medicaid program	ı(line 7 mir	nus sum of li	nes 2 and 5; if	4, 523, 129	8. 00
	< zero then enter zero)		6				
9. 00	Children's Health Insurance Program (CHIP) (Net revenue from stand-alone CHIP	see instructions	tor each iir	ne)		0	9. 00
10.00	Stand-alone CHIP charges					0	10.00
11. 00	Stand-alone CHIP cost (line 1 times line 10)					Ö	11.00
12.00	Difference between net revenue and costs for		(line 11 mi	nus line 9;	if < zero then	0	12.00
	enter zero)						
40.00	Other state or local government indigent car						40.00
13.00	Net revenue from state or local indigent car Charges for patients covered under state or					0	
14. 00	10)	rocar murgent ca	ire program ((Not Theruded	III IIIles 6 01	U	14.00
15. 00	State or local indigent care program cost (I	ine 1 times line	14)			0	15. 00
16.00	Difference between net revenue and costs for			e program (li	ne 15 minus line	0	16.00
	13; if < zero then enter zero)						
	Grants, donations and total unreimbursed cos instructions for each line)	t for Medicaid, C	HIP and stat	te/Local indi	gent care progra	ms (see	
17. 00	Private grants, donations, or endowment inco					0	
18.00	Government grants, appropriations or transfe					0	18.00
19. 00	Total unreimbursed cost for Medicaid , CHIP 8, 12 and 16)	and state and loc	ai indigent	care program	s (sum or lines	4, 523, 129	19. 00
	12 and 10)			Uni nsured	Insured	Total (col. 1	
				pati ents	pati ents	+ col . 2)	
				1. 00	2. 00	3. 00	
20. 00	Uncompensated Care (see instructions for eac Charity care charges and uninsured discounts		acility	867, 30	08	867, 308	20. 00
20.00	(see instructions)	s for the entire i	acrity	807, 30	0	807, 308	20.00
21. 00	Cost of patients approved for charity care a instructions)	and uninsured disc	ounts (see	325, 38	36 0	325, 386	21. 00
22. 00	Payments received from patients for amounts	previously writte	n off as		0 0	0	22. 00
23. 00	charity care Cost of charity care (line 21 minus line 22)			325, 38	36 0	325, 386	23. 00
	I -					1. 00	
24. 00	Does the amount on line 20 column 2, include				of stay limit	N	24. 00
25. 00	imposed on patients covered by Medicaid or o If line 24 is yes, enter the charges for pat stay limit				m's length of	0	25. 00
26. 00	Total bad debt expense for the entire hospit	al complex (see i	nstructi ons))		3, 617, 370	26. 00
27. 00	Medicare reimbursable bad debts for the enti	, ,	,			116, 054	
27. 01	Medicare allowable bad debts for the entire		(see instruc	ctions)		178, 544	
28. 00	Non-Medicare bad debt expense (see instructi		,			3, 438, 826	
29. 00	Cost of non-Medicare and non-reimbursable Me		expense (see	ı nstructi ons)	1, 352, 627	
30.00	Cost of uncompensated care (line 23 column 3 Total unreimbursed and uncompensated care co		line 30)			1, 678, 013 6, 201, 142	
31.00	Trotar uni erinour seu anu uncompensateu care co	ist (Title 14 hinz	11110 30)			0, 201, 142	31.00

Heal th	Financial Systems	FAYETTE COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C	CN: 14-1346	Peri od:	Worksheet A	
					From 07/01/2022 To 06/30/2023	Date/Time Pre	pared:
						11/29/2023 3:	
	Cost Center Description	Sal ari es	0ther		Reclassificat	Reclassified	
				+ col . 2)	i ons (See A-6)	Trial Balance (col. 3 +-	
					0)	col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	GENERAL SERVICE COST CENTERS				017 (00	047 (00	1 00
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP		0 1, 150, 023		0 217, 632 3 98	217, 632 1, 150, 121	1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	241, 242	3, 317, 782			3, 579, 491	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 726, 800	2, 604, 350			4, 183, 068	1
7.00	00700 OPERATION OF PLANT	374, 135	244, 596	618, 73	1 34, 339	653, 070	7. 00
7. 01	00701 OPERATION OF PLANT HOSP ONLY	0	1, 036, 091	1, 036, 09	1 0	1, 036, 091	
7. 02	00702 OPERATION OF PLANT ANNEX ONLY	152 012	42.000	10/ /2	0	107 (22	
8. 00 9. 00	O0800 LAUNDRY & LI NEN SERVI CE O0900 HOUSEKEEPI NG	152, 813 581, 138	43, 809 137, 887			196, 622 719, 025	1
10.00	01000 DI ETARY	470, 548	447, 621			577, 355	1
11. 00	01100 CAFETERI A	0	0	1	340, 814	340, 814	1
13.00	01300 NURSING ADMINISTRATION	234, 732	18, 373			253, 092	
14. 00	01400 CENTRAL SERVICES & SUPPLY	78, 512	560, 820			164, 485	1
15.00	01500 PHARMACY	239, 812	2, 499, 794			480, 552	1
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	475, 854	188, 465	664, 31	9 0	664, 319	16.00
30.00	03000 ADULTS & PEDIATRICS	1, 222, 857	1, 281, 437	2, 504, 29	4 -14, 223	2, 490, 071	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
44. 00	04400 SKILLED NURSING FACILITY	1, 768, 026	621, 482	2, 389, 50	8 12,000	2, 401, 508	44.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	759, 042	1, 214, 901	1, 973, 94	3 -125, 687	1, 848, 256	50.00
53. 00	05300 ANESTHESI OLOGY	759, 042	1, 214, 901	1, 973, 94	125, 067 0	1, 040, 230	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	584, 805	1, 079, 651	1, 664, 45	6 -245, 489	_	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	175, 052			335, 109	•
60.00	06000 LABORATORY	944, 872	2, 249, 566				•
65. 00	06500 RESPIRATORY THERAPY	259, 160	119, 928		· ·	359, 571	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	661, 313	74, 848			736, 161 115, 573	
68.00	06800 SPEECH PATHOLOGY	105, 315 96, 704	10, 258 8, 761			105, 465	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	70, 704	0, 701	1	209, 530		
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0)	294, 557	294, 557	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0)	0 2, 351, 039	2, 351, 039	
77. 00	07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0)	0 0	0	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	1, 050, 172	184, 811	1, 234, 98	3 -96, 208	1, 138, 775	88.00
88. 01	08801 RURAL HEALTH CLINIC II	96, 794	70, 469			234, 009	1
90.00	09000 CLI NI C	0	599, 548			599, 548	
90. 01	09002 WOUND CARE	67, 839	143, 782			211, 621	
90. 02	09003 PAIN MANAGEMENT	0	107, 000	107, 00	51, 562	158, 562	
90. 03	O9001 NEUROLOGY O9004 FAMI LY MEDI CI NE	264 100	24 020	200 03	U 0	0 573, 525	
	09005 SURGERY	364, 199 982, 119	34, 838 59, 702				
	09006 RHEUMATOLOGY	0	104, 300			153, 727	
90. 07	09007 PULMONOLOGY	0	126, 000				•
90. 08	04950 FAMILY MEDICINE - NP	147, 937	10, 401	158, 33		158, 338	1
90.09	09008 OP NURSI NG SERVI CE	0	0)	0 119, 274	119, 274	
90. 10 91. 00	O9009 ENDDOCRI NOLOGY O9100 EMERGENCY	1, 526, 514	2, 483, 895	4, 010, 40	94, 238 5, 186		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 320, 314	2, 403, 073	4,010,40	5, 100	4,015,575	92.00
	OTHER REIMBURSABLE COST CENTERS						1
	09500 AMBULANCE SERVI CES	0	0	l	0		95. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0)	0 0	0	102.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		0	1	0 0	0	113.00
118.00	1	15, 213, 254	23, 010, 241				
	NONREI MBURSABLE COST CENTERS	,,		337 = 237		23, 223, 122	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	l	0 0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	1, 290, 001	269, 076				1
	19201 FAYETTE COUNTY ANNEX 19202 PUBLIC RELATIONS	0	104, 156	1	6 -104, 156 0 0		192. 01 192. 02
	19203 PERSONAL LAUNDRY	0	0		0 0		192. 02
	19204 6TH STREET HOURSE	Ö	3, 429	1	-		192.04
200.00	TOTAL (SUM OF LINES 118 through 199)	16, 503, 255	23, 386, 902	39, 890, 15	7 0		

 Health Financial
 Systems
 FAYETTE CO

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 14-1346

Peri od: Worksheet A From 07/01/2022 To 06/30/2023 Date/Time Prepared:

					11/29/2023 3:06 pm
Cost Center Descri	ption	Adjustments	Net Expenses		 717 277 2020 C. CO piii
	•	(See A-8)	For		
			Allocation		
		6. 00	7. 00		
GENERAL SERVICE COST CEN				T	
1. 00 00100 NEW CAP REL COSTS-		0	217, 632	1	1.00
2. 00 00200 NEW CAP REL COSTS-		0	1, 150, 121	1	2.00
4. 00 00400 EMPLOYEE BENEFITS		3, 623, 699	7, 203, 190	1	4.00
5. 00 00500 ADMI NI STRATI VE & G		-1, 442, 712	2, 740, 356	1	5.00
7. 00 00700 OPERATION OF PLANT		68, 713	721, 783		7.00
7. 01 00701 OPERATION OF PLANT		0	1, 036, 091		7. 01
7. 02 00702 OPERATION OF PLANT		٥	104 422	1	7. 02
8. 00 00800 LAUNDRY & LI NEN SE 9. 00 00900 HOUSEKEEPI NG	ERVICE	0	196, 622 719, 025		8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY		0	577, 355	1	9.00
11. 00 01100 CAFETERI A		-112, 795	228, 019	1	11.00
13. 00 01100 CALLIERTA 13. 00 01300 NURSING ADMINISTRA	ATLON	-112, 743	253, 092	1	13.00
14. 00 01400 CENTRAL SERVICES &		0	164, 485	1	14. 00
15. 00 01500 PHARMACY	301121	-22, 940	457, 612	1	15. 00
16. 00 01600 MEDICAL RECORDS &	LIRRARY	-94	664, 225	1	16.00
I NPATIENT ROUTINE SERVICE		77	004, 223	1	10.00
30. 00 03000 ADULTS & PEDIATRIC		158, 862	2, 648, 933		30.00
31. 00 03100 NTENSI VE CARE UNI		0	0	1	31.00
44. 00 04400 SKI LLED NURSI NG FA		-203, 723	2, 197, 785	1	44.00
ANCILLARY SERVICE COST (=,,		
50. 00 05000 OPERATING ROOM		-656, 035	1, 192, 221		50.00
53. 00 05300 ANESTHESI OLOGY		0	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOST	TIC I	-72	1, 418, 895		54.00
55. 00 05500 RADI OLOGY-THERAPEU		0	335, 109		55. 00
60. 00 06000 LABORATORY		0	3, 194, 112		60.00
65. 00 06500 RESPIRATORY THERAP	Υ	0	359, 571		65.00
66. 00 06600 PHYSI CAL THERAPY		0	736, 161		66.00
67. 00 06700 OCCUPATI ONAL THERA	APY	0	115, 573		67. 00
68.00 06800 SPEECH PATHOLOGY		0	105, 465		68.00
71.00 07100 MEDICAL SUPPLIES C	CHARGED TO PATIENTS	0	209, 530		71.00
72.00 07200 I MPL. DEV. CHARGED	TO PATIENT	0	294, 557		72.00
73.00 07300 DRUGS CHARGED TO P		-24, 574	2, 326, 465		73.00
77.00 07700 ALLOGENEIC HSCT AC		0	0		77. 00
OUTPATIENT SERVICE COST					
88. 00 08800 RURAL HEALTH CLINI		0	1, 138, 775	1	88.00
88. 01 08801 RURAL HEALTH CLINI	CII	0	234, 009	1	88. 01
90. 00 09000 CLI NI C		0	599, 548	1	90.00
90. 01 09002 WOUND CARE		0	211, 621	1	90. 01
90. 02 09003 PAI N MANAGEMENT		-107, 000	51, 562	1	90. 02
90. 03 09001 NEUROLOGY	•	0	0		90. 03
90. 04 09004 FAMILY MEDICINE		-320, 248	253, 277		90.04
90. 05 09005 SURGERY		-1, 044, 860	115, 934	1	90.05
90. 06 09006 RHEUMATOLOGY		-104, 208	49, 519	1	90.06
90. 07 09007 PULMONOLOGY 90. 08 04950 FAMI LY MEDI CI NE -	ND	-126, 003	45, 457 -23, 536		90. 07 90. 08
90. 08 04930 FAMILY MEDICINE - 90. 09 09008 OP NURSING SERVICE		-181, 874 0			90.08
	-		119, 274		
90. 10 09009 ENDDOCRI NOLOGY 91. 00 09100 EMERGENCY		-56, 000 -589, 338	38, 238 3, 426, 257		90. 10
92. 00 09200 OBSERVATION BEDS (NON DISTINCT DART)	-307, 330	3, 420, 237		92.00
OTHER REIMBURSABLE COST					92.00
95. 00 09500 AMBULANCE SERVICES		0	0		95. 00
102. 00 10200 OPI OI D TREATMENT P		0	0		102. 00
SPECIAL PURPOSE COST CEN		υ		1	102.00
113. 00 11300 INTEREST EXPENSE		ol	0		113. 00
	LINES 1 through 117)	-1, 141, 202	37, 723, 920	1	118.00
NONREI MBURSABLE COST CEN		1, 141, 202	37, 723, 720	1	110.00
190. 00 19000 GIFT, FLOWER, COFF		n	0		190, 00
192. 00 19200 PHYSI CLANS' PRI VAT		Ö	1, 021, 606		192.00
192. 01 19201 FAYETTE COUNTY ANN		o	0 ., 52 .,		192. 01
192. 02 19202 PUBLIC RELATIONS		n	0		192. 02
192. 03 19203 PERSONAL LAUNDRY		Ö	0		192. 03
192. 04 19204 6TH STREET HOURSE		o	3, 429		192. 04
200.00 TOTAL (SUM OF LINE	S 118 through 199)	-1, 141, 202	38, 748, 955		200.00
•	-				•

Period: Worksheet A-0 From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/29/2023 3:06 pm Provider CCN: 14-1346

					11/29/2023 3	3: 06 E
	Cost Contor	Increases	Salany	Othor		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - CAFETERIA	3.00	4.00	5.00		
	CAFETERIA	11. 00	174, 662	166, 152		1.
	0		174, 662	166, 152		1
È	B - AUTO INSURANCE		17 17 002	1007 102		
	NEW CAP REL COSTS-BLDG &	1.00	0	153, 732		1
F	FI XT					
C		T		153, 732		
C	C - OCCUPATIONAL HEALTH					
0 E	EMPLOYEE BENEFITS DEPARTMENT	4. 00	16, 633	3, 834		1
C			16, 633	3, 834		
	D - WELLNESS					
0 [NEW CAP REL COSTS-BLDG &	1. 00	0	63, 900		1
F	FLXT					
	NEW CAP REL COSTS-MVBLE	2. 00	0	98		2
E	EQUI P					
) <i> </i>	ADMINISTRATIVE & GENERAL	5. 00	0	5, 650		3
	OPERATION OF PLANT	7. 00	0	34, 382		4
	DRUGS CHARGED TO PATIENTS	7300	0	126		5
	0		0	104, 156		
	E - MEDICAL SUPPLIES					
	MEDICAL SUPPLIES CHARGED TO	71. 00	0	504, 087		1
	PATI ENTS					
)		0.00	0	0		2
0		0. 00	0	0		3
)		0.00	0	0		4
)		0. 00	0	0		5
0		0. 00	0	0		6
0		0.00	0	0		7
)		0. 00	0	0		8
) [0.00	0	0		9
	0		0	504, 087		
	F - DRUGS					
	DRUGS CHARGED TO PATIENTS	73. 00	0	2, 350, 913		1
)		0. 00	0	0		2
)		0. 00	0	0		3
)		0. 00	0	0		4
0		0. 00	0	0		5
0		0. 00	0	0		6
0		0. 00	0	0		7
)		0. 00	0	0		8
0		0.00	0	0		9
OO [000	0	0		10
	0		0	2, 350, 913		
	G - IMPLANTABLES					
	IMPL. DEV. CHARGED TO	72. 00	0	294, 557		1
F	PATI ENT					
	0		0	294, 557		
<u> </u>	H - SPECIALTY CLINIC					
	PAIN MANAGEMENT	90. 02	45, 923	5, 639		1
	FAMILY MEDICINE	90. 04	166, 302	20, 421		2
	SURGERY	90. 05	105, 976	13, 014		3
	RHEUMATOLOGY	90. 06	44, 021	5, 406		4
	PULMONOLOGY	90. 07	40, 488	4, 972		5
) <u>E</u>	ENDDOCRI NOLOGY	<u>90.</u> 10	3 <u>7, 4</u> 99	<u>4, 6</u> 05		6
	0		440, 209	54, 057		_
I	- PROVIDER BASED RECLASS					
) <u>E</u>	ENDDOCRI NOLOGY	90.10	0	<u>52, 2</u> 00		1
[0	0		0	52, 200		_
	J - OP NURSING SERVICE					
) [OP_NURSING_SERVICE	<u>90.</u> 09	101, 525	1 <u>7, 7</u> 49		1
	0		101, 525	17, 749		_
	K - RADIOLOGY ADMINISTRATION					
) <u>F</u>	RADI OLOGY-THERAPEUTI C	5500	113, 225	<u>52, 6</u> 59		1
[0	0		113, 225	52, 659		_
	L - MEDICAL DIRECTOR RECLASS					
	EMERGENCY	91. 00	12, 000	0		1
) [SKILLED NURSING FACILITY	4400	1 <u>2, 0</u> 00	0		2
C			24, 000	0		
N	M - RHC OFFICE MANAGER RECLASS					
o F	RURAL HEALTH CLINIC II	88. 01	4, 214	0] 1
o F	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	29, 462	0		2
- 1			33, 676			1

Heal th I	Financial Systems		FAYETTE COUN	ITY HOSPI TAL		In Lieu	u of Form CMS-	-2552-10
RECLASS	SIFICATIONS			Provi der 0	CCN: 14-1346	Peri od: From 07/01/2022		
						To 06/30/2023	Date/Time Pro 11/29/2023 3	
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	N - RHC PHYSICIAN ASSISTANT I	RECLASS						
1. 00	RURAL HEALTH CLINIC II	88. 01	61, 329	1, 203				1.00
	TOTALS		61, 329	1, 203				
500.00	Grand Total: Increases		965, 259	3, 755, 299				500.00

| Peri od: | Worksheet A-6 | From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: Provider CCN: 14-1346

					То	/Time Prepare 9/2023 3:06 p
	Cost Center	Decreases Li ne #	Sal ary	Other	Wkst. A-7 Ref.	
	6.00	7. 00	8. 00	9. 00	10.00	
	A - CAFETERIA					
00	DI ETARY	1000	174, 662	16 <u>6, 1</u> 52	0	1.
	B - AUTO INSURANCE		174, 662	166, 152		
00	ADMI NI STRATI VE & GENERAL	5. 00	O	153, 732	12	1.
, ,	0			153, 732		'
	C - OCCUPATIONAL HEALTH					
00	PHYSICIANS' PRIVATE OFFICES	<u>192.</u> 00	<u>16, 6</u> 33	3, 834	0	1.
	0 D WELLNESS		16, 633	3, 834		
00	D - WELLNESS FAYETTE COUNTY ANNEX	192. 01	O	104, 156	O	1.
0	TATETTE COUNTT ANNEX	0.00	o	104, 130	9	2
0		0. 00	o	0	O	3
0		0. 00	О	0	0	4.
0		0.00	•	0	0	5.
	0 L		0	104, 156		
0	E - MEDICAL SUPPLIES OPERATION OF PLANT	7. 00	ol	43	0	1.
00	CENTRAL SERVICES & SUPPLY	14. 00	o	474, 847	0	2.
0	ADULTS & PEDIATRICS	30. 00	Ö	430	Ö	3
0	OPERATING ROOM	50. 00	0	5, 723	0	4.
0	RADI OLOGY-DI AGNOSTI C	54. 00	0	2, 382	0	5
0	LABORATORY	60.00	0	326	0	6
0	RESPIRATORY THERAPY	65. 00	0	19, 517	0	7
0 0	FAMILY MEDICINE EMERGENCY	90. 04 91. 00	0	186 633	0	8 9
O	0			504, 087		, ,
	F - DRUGS			55.7551	<u> </u>	
0	PHARMACY	15. 00	0	2, 259, 054	0	1
0	ADULTS & PEDIATRICS	30. 00	0	1, 793	0	2
0	OPERATING ROOM	50.00	0	690	0	3
0 0	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54. 00 55. 00	0	77, 223	0	5
0	NURSING ADMINISTRATION	13. 00	0	5, 827 13	0	6
0	FAMILY MEDICINE	90. 04	o	49	0	7
0	SURGERY	90. 05	o	17	o	8
0	ENDDOCRI NOLOGY	90. 10	0	66	0	9.
00	EMERGENCY	<u>91.</u> 00	0	<u>6, 1</u> 81	0	10
	0		0	2, 350, 913		
0	G - IMPLANTABLES MEDICAL SUPPLIES CHARGED TO	71. 00	O	294, 557	0	1.
U	PATI ENTS	71.00	J	274, 557	o o	'
	0	+		294, 557		
	H - SPECIALTY CLINIC			·		
0	PHYSICIANS' PRIVATE OFFICES	192. 00	440, 209	54, 057	0	1
0		0. 00	0	0	0	2
)		0.00	0	0	0	3
0 0		0. 00 0. 00	O O	0	0	4 5
0		0.00	0	0	0	6
0			440, 209	54, 057	— — -	
	I - PROVIDER BASED RECLASS					
0	PHYSICIANS' PRIVATE OFFICES	192.00	0	52, 200		1
	0		0	52, 200		
_	J - OP NURSING SERVICE	50.00	404 505	47.740		
0	OPERATING ROOM	<u>50.</u> 00	10 <u>1, 5</u> 25 101, 525	1 <u>7, 7</u> 49 17, 749		1
	K - RADIOLOGY ADMINISTRATION		101, 525	17, 749		
)	RADI OLOGY-DI AGNOSTI C	54. 00	113, 225	52, 659	0	1
	0		113, 225	52, 659		
	L - MEDICAL DIRECTOR RECLASS					
)	FAMILY MEDICINE	90. 04	12, 000	0		1
C	ADULTS & PEDI ATRI CS	3000	12,000	0	0	2
	O M - RHC OFFICE MANAGER RECLASS	<u> </u>	24, 000	0		
C	N - RHC OFFICE MANAGER RECLASS	88. 00	33, 676	0	0	1
)	HENEIN CEINIO	0.00	0	0	0	2
			33, 676			
	N - RHC PHYSICIAN ASSISTANT RE	CLASS			<u>'</u>	
0	RURAL HEALTH CLINIC TOTALS	88. 00	61, 329 61, 329	1, 203 1, 203	0	1.

| Peri od: | Worksheet A-7 | From 07/01/2022 | Part | To 06/30/2023 | Date/Time Prepared:

Acquisitions Beginning Balances Donation Total Disposals and Retirements Donation Retirements Donation Documents
Beginning Purchases Donation Total Disposals and Retirements
1.00 2.00 3.00 4.00 5.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 0 0 0 0 0 1.00
PART - ANALYSIS OF CHANGES N CAPITAL ASSET BALANCES
1.00 Land 0 0 0 0 0 1.00
2 OO Land Improvements Ol Ol Ol Ol Ol Ol Ol Ol
3.00 Buildings and Fixtures 0 0 0 0 0 3.00
4.00 Building Improvements 0 0 0 0 4.00
5.00 Fixed Equipment 0 0 0 0 0 5.00
6.00 Movable Equipment 7,474,715 10,402,030 0 10,402,030 0 6.00
7.00 HIT designated Assets 1,898,111 875,103 0 875,103 0 7.00
8.00 Subtotal (sum of lines 1-7) 9,372,826 11,277,133 0 11,277,133 0 8.00
9.00 Reconciling Items 0 0 0 0 0 9.00
10.00 Total (line 8 minus line 9) 9, 372, 826 11, 277, 133 0 11, 277, 133 0 10.00
Ending Fully
Balance Depreciated
Assets
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES
1.00 Land 0 0 1.00
2.00 Land Improvements 0 0 2.00 3.00 Buildings and Fixtures 0 0 3.00
4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 0 0 5.00
6. 00 Movable Equipment 17, 876, 745 0 6. 00
7. 00 HIT designated Assets 2, 773, 214 0 7. 00
8.00 Subtotal (sum of lines 1-7) 20,649,959 0 8.00
9. 00 Reconciling Items 0 0 9. 00
10.00 Total (line 8 minus line 9) 20,649,959 0
10.00 [10.00]

Heal th	Financial Systems	FAYETTE COUNT	ΓΥ HOSPI TAL		In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co	CN: 14-1346	Peri od: From 07/01/2022 To 06/30/2023		pared:	
			Sl	JMMARY OF CAP	TTAL			
	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	MN 2, LINES 1 a	and 2				
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	0		0 0	0	1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1, 150, 023	0		0 0	0	2.00	
3.00	Total (sum of lines 1-2)	1, 150, 023	0		0 0	0	3.00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	Other	Total (1)					
		Capi tal -Relat	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1, 150, 023				2.00	
3. 00	Total (sum of lines 1-2)	0	1, 150, 023				3.00	

Health Financial Systems	FAYETTE COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co	1	Period: From 07/01/2022 Fo 06/30/2023		pared:
	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITA					
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1. 00	2.00	col . 2) 3.00	4.00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00	
1. 00 NEW CAP REL COSTS-BLDG & FLXT	0	0		0.000000	0	1.00
2. 00 NEW CAP REL COSTS-MVBLE EQUIP	20, 649, 959	l o	20, 649, 959		Ö	2. 00
3.00 Total (sum of lines 1-2)	20, 649, 959		20, 649, 959			3. 00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				F CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)			
DADT III DECONOLILIATION OF CARLTH COOTS	6. 00	7. 00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 NEW CAP REL COSTS-BLDG & FIXT	ENTERS O	1 0	1 ,	63, 900	0	1. 00
2.00 NEW CAP REL COSTS-BLDG & FIXT	0	0)	1, 150, 121	0	2.00
3.00 Total (sum of lines 1-2)	0	1)	1, 130, 121	0	3.00
3.00 Total (Suil of Titles 1-2)	0	U	JMMARY OF CAPI		0	3.00
		00	Juliu 11 01 07 11 1			
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see	9 through 14)	
	11.00	10.00	10.00	instructions)	45.00	
DART III DECONCILIATION OF CARLTAL COSTS C	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 NEW CAP REL COSTS-BLDG & FIXT	ENTERS	153, 732	1	0	217, 632	1. 00
2. 00 NEW CAP REL COSTS-MVBLE EQUIP	0				1, 150, 121	2.00
3.00 Total (sum of lines 1-2)	Ö	1				
	'		1	- 1	.,, , , , ,	

AD3031	MENTS TO EXPENSES			Provider CCN: 14-1346	From 07/01/2022 To 06/30/2023	Date/Time Pre 11/29/2023 3:	pared:
			Т	Expense Classification coorrow Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4.00	Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		0 N	IEW CAP REL COSTS-BLDG &	1. 00	0	1. 00
2. 00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		0 0	IEW CAP REL COSTS-MVBLE QUIP	2. 00	0	2. 00
3. 00	2) Investment income - other (chapter 2)	В	-2, 504 A	DMINISTRATIVE & GENERAL	5. 00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5. 00	Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter	А	-1, O11 A	DMINISTRATIVE & GENERAL	5. 00	0	7. 00
8. 00	21) Tel evi si on and radio servi ce		0		0. 00	0	8. 00
9. 00 10. 00	(chapter 21) Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -2, 532, 235		0.00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.	A-0-2	-2, 332, 233		0.00	0	
12. 00	(chapter 23) Related organization	A-8-1	2, 453, 611			0	
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee and others	В	-111, 899 C	AFETERI A	11. 00 0. 00	0	14.00
16. 00	Sale of medical and surgical supplies to other than patients		0		0. 00	0	16. 00
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and	В	-94 N	IEDI CAL RECORDS & LI BRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vendi ng machi nes	В	-896	AFETERI A	11. 00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	OF	ESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	OF	PHYSI CAL THERAPY	66. 00		24.00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0 *	** Cost Center Deleted **	* 114.00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL			IEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL		0	IXT IEW CAP REL COSTS-MVBLE	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		l l	QUIP ** Cost Center Deleted **			28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0 0 0	CCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 99	therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see	5 5			30.00		30. 99
30. 99	instructions)			DULTS & PEDIATRICS	30.00		30. 99

Heal th	Financial Systems		FAYETTE COUN	TY HOSPITAL	In Lie	u of Form CMS-:	2552-10
	MENTS TO EXPENSES				eri od:	Worksheet A-8	
				F	rom 07/01/2022		
					o 06/30/2023	Date/Time Pre 11/29/2023 3:	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center bescription	(2)	Amount	COST CENTER	LITIC #	Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00	0.00	31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
33.00	EMPLOYEE BENEFITS MISC REVENUE	В	0	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33.00
33. 01	ADMINISTRATIVE & GENERAL MISC	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
	REVENU						
33. 02	LTC MISC REVENUE	В		SKILLED NURSING FACILITY	44. 00	0	00.02
33. 03	RADIOLOGY MISC INCOME	В		RADI OLOGY-DI AGNOSTI C	54. 00	0	1 00.00
33.04	LABOARATORY MISC INCOME	В		LABORATORY	60.00	0	33.04
33. 05	PHARMACY MISC INCOME	В	· ·	DRUGS CHARGED TO PATIENTS	73. 00	0	33. 05
33. 06	DR FUNNEMAN MISC REVENUE	В		RURAL HEALTH CLINIC	88. 00	0	33.06
33. 07	DR SKOW MISC REVENUE	В		FAMILY MEDICINE	90. 04	0	33. 07
34.00	DR BLASER MI SC REVENUE	В		SURGERY	90. 05	0	34.00
34. 01 34. 02	DR RONHOLM MISC REVENUE	B B		RHEUMATOLOGY PULMONOLOGY	90.06	0	34. 01 34. 02
34. 02	DR. BARKOVIAK MISC REVENUE ER MISC REVENUE	B B		EMERGENCY	90. 07	0	34.02
34. 03	AHA LOBBYING DUES PERCENTAGE	A A		ADMINISTRATIVE & GENERAL	91. 00 5. 00	0	34.03
34. 05	THA LOBBYING DUES PERCENTAGE	A		ADMINISTRATIVE & GENERAL	5. 00	0	
34.05	340B EXPENSE OFFSET	A A		PHARMACY	15. 00	0	1
34. 00	OTHER INCOME - SNF TAX REVENUE			SKILLED NURSING FACILITY	44. 00		34.00
34. 07	LTC MEDCALD ASSESSMENT	A		SKILLED NURSING FACILITY	44.00	0	34.07
34. 09	MARKETI NG EXPENSE	Ä		ADMINISTRATIVE & GENERAL	5. 00		34.09
34. 10	CRNA EXPENSE OFFSET	Ä		OPERATING ROOM	50.00		34. 10
50.00	TOTAL (sum of lines 1 thru 49)		-1, 141, 202		23.00		50.00
55.50	(Transfer to Worksheet A,		., , 202				30.00
	column 6 Line 200)						

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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1346

Peri od: Worksheet A-8-1 From 07/01/2022 To 06/30/2023 Date/Time Prepared

Line No. Cost Center Expense I tems Amount of Allowable Cost Included in Wks. A, column 1.00 2.00 3.00 4.00 5.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: DIAGNOSTIC SHARED SERVICES LAB SAMPLE PROCESSING 993, 298 993, 298 2.00 3.00 1.00 NEW CAP REL COSTS-BLDG & FIX SARAH BUSH LINCOLN 153, 732 153, 732 3.00 3.01 4.00 EMPLOYEE BENEFITS DEPARTMENT SARAH BUSH LINCOLN 3, 776, 329 152, 630 3.01 3.02 5.00 ADMINISTRATIVE & GENERAL SARAH BUSH LINCOLN 114, 590 1, 515, 250 3.02 3.03 3.04 3.00 ORADIOLOGY-DIAGNOSTIC SARAH BUSH LINCOLN 68, 713 0 3.03 3.05 5 SARAH BUSH LINCOLN 161, 859 0 3.04 3.06 90.05 SURGERY SARAH BUSH LINCOLN 142, 857 142, 857 3.05 3.06 90.05 SURGERY SARAH BUSH LINCOLN 1, 010, 438 1, 010, 438 3.06 3.08 192.00 PHYSICIANS' PRIVATE OFFICES SARAH BUSH LINCOLN 20, 915 220, 915 3.09 4.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.					10 06/30/2023	11/29/2023 3:	
A I Owable Cost I I Columb Wks. A Column Cost Columb Cost Co		Li ne No.	Cost Center	Expense Items	Amount of		00 p
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1. 00 2. 00 60. 00 LABORATORY 2. 00 60. 00 LABORATORY 3. 00 1. 00 NEW CAP REL COSTS-BLDG & FI X SARAH BUSH LINCOLN 3. 01 3. 02 3. 01 3. 02 3. 03 3. 04 4. 00 EMPLOYEE BENEFITS DEPARTMENT SARAH BUSH LINCOLN 3. 776, 329 152, 630 3. 01 3. 02 3. 03 3. 04 3. 05 4. 00 PERATION OF PLANT SARAH BUSH LINCOLN 3. 05 5. 00 ADMINISTRATIVE & GENERAL SARAH BUSH LINCOLN 3. 05 5. 00 ADMINISTRATIVE & GENERAL SARAH BUSH LINCOLN 3. 05 5. 00 ADMINISTRATIVE & GENERAL SARAH BUSH LINCOLN 3. 05 5. 00 ADMINISTRATIVE & GENERAL SARAH BUSH LINCOLN 3. 05 5. 00 ADMINISTRATIVE & GENERAL SARAH BUSH LINCOLN 3. 05 5. 00 ADMINISTRATIVE & GENERAL SARAH BUSH LINCOLN 3. 05 5. 00 ADMINISTRATIVE & GENERAL SARAH BUSH LINCOLN 5. 00 ADMINISTRATIVE & GEN				·	Allowable Cost	Included in	
1.00						Wks. A, column	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 2.00 3.00 3.00 3.01 4.00 EMPLOYEE BENEFITS DEPARTMENT SARAH BUSH LINCOLN 153, 732 153, 732 3.00 3.02 3.03 3.04 5.00 ADMINISTRATIVE & GENERAL SARAH BUSH LINCOLN 114, 590 1, 515, 250 3.02 3.04 3.05 3.05 3.06 3.06 3.07 3.08 4.00 CABDRATION OF PLANT SARAH BUSH LINCOLN 164, 730 1, 515, 250 3.04 3.05 3.06 3.07 3.08 3.09 4.00 CABDRATION OF PLANT SARAH BUSH LINCOLN 161, 859 0 3.04 3.05 3.06 3.07 3.08 3.09 4.00 CABDRATION OF PLANT SARAH BUSH LINCOLN 161, 859 0 3.04 3.07 3.08 3.09 4.00 CABDRATION OF PLANT SARAH BUSH LINCOLN 161, 859 0 3.04 3.08 3.09 4.00 CABDRATION OF PLANT SARAH BUSH LINCOLN 161, 859 0 3.04 3.08 3.09 4.00 CABDRATION OF PLANT SARAH BUSH LINCOLN 161, 859 0 3.04 3.08 3.09 4.00 CABDRATION OF PLANT SARAH BUSH LINCOLN 161, 859 0 3.04 3.08 3.09 4.00 CABDRATION OF PLANT SARAH BUSH LINCOLN 161, 859 0 3.04 3.08 3.09 4.00 CABDRATION OF PLANT SARAH BUSH LINCOLN 161, 859 0 3.04 3.08 3.09 4.00 CABDRATION OF PLANT SARAH BUSH LINCOLN 161, 859 0 3.04 3.08 3.09 4.00 CABDRATION OF PLANT SARAH BUSH LINCOLN 161, 859 0 3.04 3.08 3.09 4.00 CABDRATION OF PLANT SARAH BUSH LINCOLN 161, 859 0 3.04 3.08 3.09 4.00 CABDRATION OF PLANT SARAH BUSH LINCOLN 161, 859 0 3.04 3.08 3.09 4.00 CABDRATION OF PLANT SARAH BUSH LINCOLN 161, 859 0 3.04 3.09 4.00 5.00 5.00 TOTALS (Sum of Lines 1-4). Transfer column 6, Line 5 to Worksheet A-8, column 2,						5	
1. 00 2. 00 3. 00 4. 00 RADI OLOGY-DI AGNOSTI C 2. 00 3. 00 3. 00 3. 01 3. 01 3. 01 3. 01 3. 02 3. 02 3. 03 3. 03 3. 04 3. 03 3. 04 3. 05 3. 04 3. 05 3. 06 3. 07 5. 00 RADI OLOGY-DI AGNOSTI C 6. 00 6. 00 LAB SAMPLE PROCESSI NG 6. 00 NEW CAP REL COSTS-BLDG & FI X 5. ARAH BUSH LI NCOLN 7. 00 PERATIMENT 7. 00 OPERATI ON OF PLANT 7. 00 OPERATION OF PLANT 7. 10		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00		A. COSTS INCURRED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OF	CLAIMED HOME	
2. 00 ABORATORY LAB SAMPLE PROCESSING 993, 298 993, 298 2. 00 3. 00 1. 00 NEW CAP REL COSTS-BLDG & FIX SARAH BUSH LINCOLN 153, 732 153, 732 3. 00 3. 01 4. 00 EMPLOYEE BENEFITS DEPARTMENT SARAH BUSH LINCOLN 3, 776, 329 152, 630 3. 01 3. 02 5. 00 ADMINISTRATIVE & GENERAL SARAH BUSH LINCOLN 114, 590 1, 515, 250 3. 02 3. 03 7. 00 OPERATION OF PLANT SARAH BUSH LINCOLN 68, 713 0 3. 03 3. 04 30. 00 ADULTS & PEDIATRICS SARAH BUSH LINCOLN 161, 859 0 3. 04 3. 05 54. 00 RADIOLOGY-DIAGNOSTIC SARAH BUSH LINCOLN 142, 857 142, 857 3. 05 3. 06 90. 05 SURGERY SARAH BUSH LINCOLN 1, 010, 438 1, 010, 438 3. 06 3. 07 90. 08 FAMILY MEDICINE - NP SARAH BUSH LINCOLN 6, 698 6, 698 3. 07 3. 08 192. 00 PHYSICIANS' PRIVATE OFFICES SARAH BUSH LINCOLN 220, 915 220, 915 3. 09 4. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,		OFFICE COSTS:					i
3. 00 1. 00 NEW CAP REL COSTS-BLDG & FIX SARAH BUSH LINCOLN 153, 732 153, 732 3. 00 3. 01 4. 00 EMPLOYEE BENEFITS DEPARTMENT SARAH BUSH LINCOLN 3, 776, 329 152, 630 3. 01 3. 02 5. 00 ADMINISTRATIVE & GENERAL SARAH BUSH LINCOLN 114, 590 1, 515, 250 3. 02 3. 03 7. 00 OPERATION OF PLANT SARAH BUSH LINCOLN 68, 713 0 3. 03 3. 03 3. 00 ADULTS & PEDIATRICS SARAH BUSH LINCOLN 161, 859 0 3. 04 30. 00 ADULTS & PEDIATRICS SARAH BUSH LINCOLN 161, 859 0 3. 04 3. 05 SURGERY SARAH BUSH LINCOLN 142, 857 142, 857 3. 05 3. 07 90. 08 FAMILY MEDICINE - NP SARAH BUSH LINCOLN 1, 010, 438 1, 010, 438 3. 06 3. 08 3. 09 192. 00 PHYSICIANS' PRIVATE OFFICES SARAH BUSH LINCOLN 308, 369 308, 369 3. 08 3. 09 192. 00 PHYSICIANS' PRIVATE OFFICES SARAH BUSH LINCOLN 220, 915 220, 915 3. 09 0 0 0 0 0 0 0 0 0	1.00	54.00	RADI OLOGY-DI AGNOSTI C	DIAGNOSTIC SHARED SERVICES	202, 354	202, 354	1.00
3. 01	2.00	60.00	LABORATORY	LAB SAMPLE PROCESSING	993, 298	993, 298	2.00
3. 02 5. 00 ADMINISTRATIVE & GENERAL SARAH BUSH LINCOLN 114,590 1,515,250 3. 02 3. 03 3. 04 30. 00 ADULTS & PEDIATRICS SARAH BUSH LINCOLN 161,859 0 3. 04 3. 05 54. 00 RADIOLOGY-DIAGNOSTIC SARAH BUSH LINCOLN 142,857 142,857 3. 05 3. 06 90. 05 SURGERY SARAH BUSH LINCOLN 1,010,438 1,010,438 3. 06 3. 07 90. 08 FAMILY MEDICINE - NP SARAH BUSH LINCOLN 6,698 6,698 3. 07 3. 08 192. 00 PHYSICIANS' PRIVATE OFFICES SARAH BUSH LINCOLN 308,369 308,369 308,369 308,369 309 192. 00 PHYSICIANS' PRIVATE OFFICES SARAH BUSH LINCOLN 220,915 220,915 3. 09 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.00				153, 732	153, 732	3.00
3. 03	3. 01	4.00	EMPLOYEE BENEFITS DEPARTMENT	SARAH BUSH LINCOLN	3, 776, 329	152, 630	3. 01
3. 04 30. 00 ADULTS & PEDIATRICS SARAH BUSH LINCOLN 161,859 0 3. 04 3. 05 54. 00 RADIOLOGY-DIAGNOSTIC SARAH BUSH LINCOLN 142,857 3. 05 3. 06 90. 05 SURGERY SARAH BUSH LINCOLN 1,010,438 1,010,438 3. 06 3. 07 90. 08 FAMILY MEDICINE - NP SARAH BUSH LINCOLN 6,698 6,698 3. 07 3. 08 192. 00 PHYSICIANS' PRIVATE OFFICES SARAH BUSH LINCOLN 308,369 308,369 3. 08 3. 09 192. 00 PHYSICIANS' PRIVATE OFFICES SARAH BUSH LINCOLN 220,915 220,915 3. 09 4. 00 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,		5. 00	ADMINISTRATIVE & GENERAL	SARAH BUSH LINCOLN	114, 590	1, 515, 250	3. 02
3. 05 54. 00 RADI OLOGY-DI AGNOSTI C SARAH BUSH LI NCOLN 142, 857 142, 857 3. 05 3. 06 90. 05 SURGERY SARAH BUSH LI NCOLN 1, 010, 438 3. 06 3. 07 3. 08 90. 08 FAMI LY MEDICINE - NP SARAH BUSH LI NCOLN 6, 698 6, 698 3. 07 SARAH BUSH LI NCOLN 308, 369 308, 369 3. 08 3. 09 192. 00 PHYSI CI ANS' PRI VATE OFFICES SARAH BUSH LI NCOLN 220, 915 220, 915 3. 09 4. 00 0. 0	3. 03	7. 00	OPERATION OF PLANT	SARAH BUSH LINCOLN	68, 713	0	3. 03
3. 06 90. 05 SURGERY SARAH BUSH LINCOLN 1, 010, 438 1, 010, 438 3. 06 3. 07 90. 08 FAMILY MEDICINE - NP SARAH BUSH LINCOLN 6, 698 6, 698 3. 07 3. 08 192. 00 PHYSICIANS' PRIVATE OFFICES SARAH BUSH LINCOLN 308, 369 308, 369 3. 08 4. 00 0. 00 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	3. 04	30.00	ADULTS & PEDIATRICS	SARAH BUSH LINCOLN	161, 859	0	3.04
3. 07 90. 08 FAMILY MEDICINE - NP SARAH BUSH LINCOLN 6, 698 6, 698 3. 07 3. 08 192. 00 PHYSICIANS' PRIVATE OFFICES SARAH BUSH LINCOLN 308, 369 308, 369 3. 08 4. 00 0. 00 0. 00 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	3.05	54.00	RADI OLOGY-DI AGNOSTI C	SARAH BUSH LINCOLN	142, 857	142, 857	3. 05
3. 08	3.06	90.05	SURGERY	SARAH BUSH LINCOLN	1, 010, 438	1, 010, 438	3.06
3.09	3.07	90.08	FAMILY MEDICINE - NP	SARAH BUSH LINCOLN	6, 698	6, 698	3. 07
4.00 0.00 0 4.00 0.00 0 0 4.706,541 5.00 0 0 0 0 0 0 0 0 0	3.08	192. 00	PHYSICIANS' PRIVATE OFFICES	SARAH BUSH LINCOLN	308, 369	308, 369	3.08
5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	3.09	192. 00	PHYSICIANS' PRIVATE OFFICES	SARAH BUSH LINCOLN	220, 915	220, 915	3. 09
Transfer column 6, line 5 to Worksheet A-8, column 2,	4.00	0.00			0	0	4.00
Worksheet A-8, column 2,	5.00	TOTALS (sum of lines 1-4).			7, 160, 152	4, 706, 541	5.00
		Transfer column 6, line 5 to					in the second
line 12.		Worksheet A-8, column 2,					i e
		line 12.					

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

 Boot postou to not Kondot //						
			Related Organization(s) and/or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of		
, ,		Ownershi p		Ownershi p		
1. 00	2. 00	3. 00	4. 00	5. 00		
 B. INTERRELATIONSHIP TO RELATE	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:				

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00	G	SARAH BUSH LINC	100.00	0.00	6. 00
7.00			0.00	0. 00	7.00
8.00			0.00	0. 00	8. 00
9.00			0.00	0. 00	9. 00
10.00			0.00	0. 00	10.00
100.00	G. Other (financial or	OTHER			100.00
	non-financial) specify:				

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th	Financial Syst	ems		FA	YETTE COUNT	Y HOSPITAL			In Lie	u of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI (ONS AND HOM	Provi der	CCN: 14-134	46 Pei	ri od:	Worksheet A-	8-1
OFFICE	COSTS								om 07/01/2022		
								То	06/30/2023		
	N-±	WI+ A 7 D-6								11/29/2023 3	: 06 pm
		Wkst. A-7 Ref.									
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
		RED AND ADJUST	MENTS REC	QUIRED AS A	RESULT OF	TRANSACTI ONS	WITH RELA	TED ORG	ANIZATIONS OR	CLAIMED HOME	
	OFFICE COSTS:										
1.00	0	0									1.00
2.00	0	0									2.00
3.00	0	9									3.00
3. 01	3, 623, 699	0									3. 01
3. 02	-1, 400, 660	0	, i								3. 02
3. 03	68, 713										3. 03
3. 04	161, 859										3. 04
3. 05	101,007										3. 05
3. 06	0										3. 06
3. 07											3. 00
											1
3. 08	0		1								3. 08
3. 09	0	9	1								3. 09
4.00	1 0	1 0)								4.00

The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

5.00

Related Organization(s)		
and/or Home Office		
Type of Business		
Type of business		
6. 00		
B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00	6. 00 7. 00
7. 00	7.00
8. 00	8.00
9. 00	8.00 9.00
10. 00	10.00
6. 00 7. 00 8. 00 9. 00 10. 00	10. 00 100. 00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

5.00

2, 453, 611

Provider CCN: 14-1346

						10 06/30/2023	3 Date/IIme Pro 3 11/29/2023 3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		ADULTS & PEDIATRICS	6, 323	2, 99	7 3, 326			
2.00	0.00		0		0 0			
3. 00		PAIN MANAGEMENT	107, 000			_	1	0.00
4. 00		FAMILY MEDICINE	341, 453		·	l .	0	
5. 00		SURGERY	1, 045, 103				0	
6. 00		RHEUMATOLOGY	104, 184			,	0	6.00
7. 00		PULMONOLOGY	126, 000				0	
8. 00		FAMILY MEDICINE - NP	181, 874				0	0.00
9. 00		OP NURSING SERVICE	0		0		0	
10. 00 11. 00		ENDDOCRI NOLOGY EMERGENCY	56, 000 2, 094, 799					10. 00 11. 00
200.00	91.00	EMERGENCY				l .		1
	Wkst. A Line #	Cost Center/Physician	4, 062, 736 Unadj usted RCE			Provi der	Physician Cost	
	WKSt. A LITTE #	I denti fi er	Li mi t		E Memberships &	Component	of Malpractice	
		ruentirrei		Li mi t	Continuing	Share of col.	Insurance	
				Li iiii t	Education	12	Trisurance	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00		ADULTS & PEDIATRICS	0		0 0			1. 00
2.00	0.00		0		0 0	0	0	2.00
3.00	90. 02	PAIN MANAGEMENT	0		0 0	0	0	3.00
4.00	90. 04	FAMILY MEDICINE	0		0 0	0	0	4.00
5.00	90. 05	SURGERY	0		0 0	0	0	5.00
6.00	90. 06	RHEUMATOLOGY	0		0 0	0	0	6.00
7.00	90. 07	PULMONOLOGY	0		0 0	0	0	7. 00
8.00	90. 08	FAMILY MEDICINE - NP	0		0 0	0	0	8. 00
9. 00		OP NURSING SERVICE	0		0 0	0	0	9. 00
10.00		ENDDOCRI NOLOGY	0		0 0	0	0	
11. 00	91. 00	EMERGENCY	0		0 0	_	0	
200.00			0		0 0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE		Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	0		0 0			1. 00
2. 00	0.00		l o		o c			2.00
3. 00	90. 02	PAIN MANAGEMENT	0		0 0	107, 000		3.00
4.00		FAMILY MEDICINE	0		0 0		•	4.00
5. 00		SURGERY	0		0 0	1		5.00
6.00		RHEUMATOLOGY	0		0 0			6.00
7. 00	90. 07	PULMONOLOGY	0		0 0	126, 000		7. 00
8.00	90. 08	FAMILY MEDICINE - NP	0		0 0	181, 874		8. 00
9.00	90. 09	OP NURSING SERVICE	0		0 0	0		9. 00
10.00	90. 10	ENDDOCRI NOLOGY	0		0 0	56, 000		10.00
11.00	91. 00	EMERGENCY	0		0 0			11. 00
200.00			0		0 0	2, 532, 235		200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 07/01/2022 | Part I | To 06/30/2023 | Date/Time Prepared: Provider CCN: 14-1346

					To	06/30/2023	Date/Time Pre 11/29/2023 3:	
				CAPI TAL REI	ATED COSTS		11/27/2023 3.	оо рііі
		Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
			for Cost Allocation	FLXT	EQUI P	BENEFITS DEPARTMENT		
			(from Wkst A			DELAKTIMENT		
			col . 7)					
			0	1.00	2.00	4. 00	4A	
4 00		AL SERVICE COST CENTERS	047 (00	047 (00		-		4 00
1. 00 2. 00		NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP	217, 632 1, 150, 121	217, 632	1, 150, 121			1. 00 2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	7, 203, 190	756		7, 205, 841		4.00
5. 00		ADMINISTRATIVE & GENERAL	2, 740, 356	15, 134		765, 943	3, 864, 174	5. 00
7.00		OPERATION OF PLANT	721, 783	75, 770	34, 961	165, 952	998, 466	7.00
7. 01		OPERATION OF PLANT HOSP ONLY	1, 036, 091	0		0	1, 036, 091	7. 01
7. 02 8. 00		OPERATION OF PLANT ANNEX ONLY LAUNDRY & LINEN SERVICE	104 422	0 5, 005	-	0 47 792	201 504	7. 02 8. 00
9. 00		HOUSEKEEPING	196, 622 719, 025	2, 325		67, 782 257, 771	281, 596 983, 690	9. 00
10.00		DI ETARY	577, 355	4, 639		131, 244	732, 733	
11. 00		CAFETERI A	228, 019	2, 736	11, 498	77, 473	319, 726	11.00
13.00		NURSING ADMINISTRATION	253, 092	1, 226		104, 118	358, 436	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	164, 485	1, 655		34, 825	200, 965	14. 00 15. 00
16.00		MEDICAL RECORDS & LIBRARY	457, 612 664, 225	1, 503 1, 323		106, 371 211, 071	583, 621 888, 631	16.00
10.00		I ENT ROUTI NE SERVI CE COST CENTERS	001, 220	1,020	12,012	211,071	000, 001	10.00
30.00		ADULTS & PEDIATRICS	2, 648, 933	11, 897	14, 986	537, 090	3, 212, 906	30. 00
31.00		INTENSIVE CARE UNIT	0	0		0	0	31.00
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	2, 197, 785	41, 537	11, 807	789, 560	3, 040, 689	44. 00
50.00		OPERATING ROOM	1, 192, 221	7, 658	339, 224	291, 650	1, 830, 753	50. 00
53. 00		ANESTHESI OLOGY	0	0		0	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C	1, 418, 895	4, 653		209, 175	1, 802, 351	54.00
55.00		RADI OLOGY-THERAPEUTI C	335, 109	1, 070		50, 222	399, 079	55.00
60. 00 65. 00		LABORATORY RESPI RATORY THERAPY	3, 194, 112 359, 571	6, 748 2, 087		419, 109 114, 954	3, 703, 527 492, 758	60. 00 65. 00
66.00		PHYSI CAL THERAPY	736, 161	4, 213		293, 333	1, 034, 993	66.00
67. 00		OCCUPATI ONAL THERAPY	115, 573	285		46, 714	162, 572	67. 00
68. 00		SPEECH PATHOLOGY	105, 465	0		42, 894	148, 359	68. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	209, 530	0		0	209, 530	
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	294, 557 2, 326, 465	0		0	294, 557 2, 326, 465	72. 00 73. 00
77.00		ALLOGENEIC HSCT ACQUISITION	2, 320, 403	0		0	2, 320, 403	77.00
	OUTPA	TIENT SERVICE COST CENTERS	- 1		- 1			
88. 00		RURAL HEALTH CLINIC	1, 138, 775	0	,	423, 957	1, 565, 616	
88. 01		RURAL HEALTH CLINIC II CLINIC	234, 009	0	_	71, 725	305, 734	88. 01
90. 00 90. 01		WOUND CARE	599, 548 211, 621	2, 717 4, 472		0 30, 091	604, 895 246, 184	90. 00 90. 01
90. 02		PAIN MANAGEMENT	51, 562	788		20, 370	73, 084	90.02
90. 03	09001	NEUROLOGY	0	0	0	0	0	90. 03
90. 04		FAMILY MEDICINE	253, 277	1, 941		229, 987	486, 524	
		SURGERY	115, 934	2, 008		482, 638	601, 422	
90. 06 90. 07		RHEUMATOLOGY PULMONOLOGY	49, 519 45, 457	377 377		19, 526 17, 959	69, 772 64, 114	90. 06 90. 07
90. 08		FAMILY MEDICINE - NP	-23, 536	681		65, 619	42, 764	90.08
90.09	09008	OP NURSING SERVICE	119, 274	1, 231		45, 033	165, 538	90. 09
90. 10	1	ENDDOCRI NOLOGY	38, 238	0		16, 633	55, 169	90. 10
91. 00 92. 00		EMERGENCY	3, 426, 257	4, 584	16, 666	682, 426	4, 129, 933	91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS					0	92. 00
95. 00		AMBULANCE SERVICES	0	0	0	0	0	95. 00
102.00		OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
440.00		AL PURPOSE COST CENTERS						440.00
113.00		INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	37, 723, 920	211, 396	1, 132, 480	6, 823, 215	37, 317, 417	113.00
110.00		IMBURSABLE COST CENTERS	31,123,120	211, 370	1, 132, 400	0, 023, 213	37, 317, 417	110.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	763	0	0	763	190. 00
	1	PHYSICIANS' PRIVATE OFFICES	1, 021, 606	5, 473		382, 626	1, 425, 977	
		FAYETTE COUNTY ANNEX PUBLIC RELATIONS	0	0	0	0		192. 01 192. 02
		PERSONAL LAUNDRY	0	0	0	o n		192. 02 192. 03
		6TH STREET HOURSE	3, 429	0	1, 369	ő		192.03
200.00		Cross Foot Adjustments					0	200. 00
201.00		Negative Cost Centers	20 740 055	0	1 150 101	7 205 044		201.00
202.00	7	TOTAL (sum lines 118 through 201)	38, 748, 955	217, 632	1, 150, 121	7, 205, 841	38, 748, 955	202.00

Provider CCN: 14-1346

				T T	0 06/30/2023	Date/Time Pre 11/29/2023 3:	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	OPERATION OF	OPERATION OF	LAUNDRY &	OO piii
	·	E & GENERAL	PLANT	PLANT HOSP	PLANT ANNEX	LINEN SERVICE	
		F 00	7.00	ONLY	ONLY	0.00	
	GENERAL SERVICE COST CENTERS	5. 00	7. 00	7. 01	7. 02	8. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	3, 864, 174					5.00
7.00	00700 OPERATION OF PLANT	110, 600		l e			7.00
7. 01	00701 OPERATION OF PLANT HOSP ONLY	114, 768	(1, 150, 859	0		7.01
7. 02 8. 00	00702 OPERATION OF PLANT ANNEX ONLY 00800 LAUNDRY & LINEN SERVICE	0 31, 192	46, 359	9 49, 223	0	408, 370	7. 02 8. 00
9. 00	00900 HOUSEKEEPING	108, 963	21, 533		0	38, 760	9.00
10.00	01000 DI ETARY	81, 165			0	2, 700	10.00
11.00	01100 CAFETERI A	35, 416			0	1, 593	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	39, 704	11, 357	7 12, 058	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	22, 261	15, 334		0	0	14.00
15. 00	01500 PHARMACY	64, 648			0	-	15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	98, 434	12, 258	3 13, 015	0	0	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	355, 894	110, 195	117, 003	0	60, 408	30.00
31. 00	03100 I NTENSI VE CARE UNI T	333, 674	110, 175		0		31.00
44. 00	04400 SKILLED NURSING FACILITY	336, 817	384, 74	-	0		44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	202, 793	70, 936	75, 319	0	19, 687	50.00
53.00	05300 ANESTHESI OLOGY	0	(٥ -	0	1	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	199, 646			0	=,	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C 06000 LABORATORY	44, 206	1		0	588 0	55.00
60. 00 65. 00	06500 RESPIRATORY THERAPY	410, 240 54, 583			0		60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	114, 646	1		0	18, 183	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	18, 008	1		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	16, 434	(0	0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	23, 210	l e	0	0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	32, 628	l e	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	257, 703		0	0	0	73.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0		0	0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	173, 423		0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	33, 866	l e	0	0	0	88. 01
90.00	09000 CLI NI C	67, 004	25, 168	0	0	0	90.00
90. 01	09002 WOUND CARE	27, 270	41, 418		0	0	90. 01
90. 02	09003 PAIN MANAGEMENT	8, 096	7, 302		0	0	90. 02
90. 03	09001 NEUROLOGY	52.002	17.07	0	0	0	90.03
90. 04 90. 05	09004 FAMILY MEDICINE 09005 SURGERY	53, 892 66, 620			0		90. 04 90. 05
90.06	09006 RHEUMATOLOGY	7, 729			0	0	90.06
90. 07	09007 PULMONOLOGY	7, 102			0	Ō	90. 07
90.08	04950 FAMILY MEDICINE - NP	4, 737	6, 308		0	0	90. 08
	09008 OP NURSING SERVICE	18, 337	11, 403	12, 108	0	0	90. 09
90. 10	· ·	6, 111	(0	0		90. 10
91.00		457, 457	42, 459	45, 082	0	40, 481	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00		0		0 0	0	0	95. 00
	10200 OPI OI D TREATMENT PROGRAM	0	.			l	102.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
118.00		3, 705, 603	1, 109, 066	1, 150, 859	0	384, 043	118. 00
400.0	NONREI MBURSABLE COST CENTERS	1 0=	Ι	J .			400 00
) 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN) 19200 PHYSICIANS' PRIVATE OFFICES	157.055			0		190.00
	19200 PHYSICIANS PRIVATE OFFICES	157, 955	(0	0		192. 00 192. 01
	2 19202 PUBLIC RELATIONS	1 0			0		192.01
	19203 PERSONAL LAUNDRY	0		ol o	0	24, 114	
	1 19204 6TH STREET HOURSE	531		0	0		192. 04
200.00	1 1						200. 00
201.00		0	(0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	3, 864, 174	1, 109, 066	1, 150, 859	0	408, 370	202. 00

Provider CCN: 14-1346

Peri od: Worksheet B From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared:

			'	0 00/30/2023	11/29/2023 3:	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	
	9. 00	10. 00	11.00	13.00	14. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT HOSP ONLY						7.00
7.01 00701 OPERATION OF PLANT HOSP ONLY 7.02 00702 OPERATION OF PLANT ANNEX ONLY						7. 01 7. 02
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG	1, 175, 809					9.00
10. 00 01000 DI ETARY	45, 978	951, 175				10.00
11. 00 01100 CAFETERI A	27, 111	0	436, 089			11.00
13.00 01300 NURSING ADMINISTRATION	12, 151	0	6, 758	440, 464		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	16, 406	0	7, 598	0	278, 845	14.00
15. 00 01500 PHARMACY	14, 894	0	9, 067		0	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	13, 115	0	26, 781	0	0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	117 000	27.4.40.4	// 440	101 105	0	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	117, 903	264, 484 0	66, 448 C	1	0	30. 00 31. 00
44.00 04400 SKILLED NURSING FACILITY	411, 658	686, 691	118, 709	1	0	44.00
ANCILLARY SERVICE COST CENTERS	411, 030	000, 091	110, 709	<u> </u>	0	44.00
50. 00 05000 OPERATING ROOM	75, 898	ol	35, 931	97, 932	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	o	03, 70.	1	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	46, 111	0	27, 158	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	10, 605	0	6, 506	0	0	55.00
60. 00 06000 LABORATORY	66, 872	0	58, 473	1	0	60.00
65. 00 06500 RESPI RATORY THERAPY	20, 678	0	13, 432		0	65.00
66. 00 06600 PHYSI CAL THERAPY	41, 756	0	C	0	0	66.00
67. 00 06700 OCCUPATIONAL THERAPY	2, 826	0			0	67. 00 68. 00
68. 00 06800 SPEECH PATHOLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0 115, 905	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0			162, 940	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o o	o	C		0	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	C	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	0	0	C		0	88. 01
90. 00 09000 CLI NI C	26, 928	0	C	0	0	90.00
90. 01 09002 WOUND CARE	44, 316	0	C	0	0	90. 01
90. 02 09003 PAI N MANAGEMENT 90. 03 09001 NEUROLOGY	7, 813	0			0	90.02
90. 04 09004 FAMI LY MEDI CI NE	19, 232	0			0	90. 03 90. 04
90. 05 09005 SURGERY	19, 897	0			0	90.05
90. 06 09006 RHEUMATOLOGY	3, 740	o	C	ol ol	0	90.06
90. 07 09007 PULMONOLOGY	3, 740	0	C	0	0	90. 07
90.08 04950 FAMILY MEDICINE - NP	6, 749	0	C	0	0	90. 08
90. 09 09008 OP NURSI NG SERVI CE	12, 201	0	C	0	0	90. 09
90. 10 09009 ENDDOCRI NOLOGY	0	0	C	0	0	90. 10
91. 00 09100 EMERGENCY	45, 429	0	59, 228	161, 427	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	0	C	ol ol	0	95.00
102.00 10200 OPI OI D TREATMENT PROGRAM		o	C			102.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u></u>		٥١		
113. 00 11300 NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 114, 007	951, 175	436, 089	440, 464	278, 845	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 563	0	C			190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	54, 239	0	C	1		192.00
192. 01 19201 FAYETTE COUNTY ANNEX	0	0	C			192.01
192. 02 19202 PUBLI C RELATI ONS 192. 03 19203 PERSONAL LAUNDRY		0				192. 02 192. 03
192.04 19204 6TH STREET HOURSE		0				192.03
200.00 Cross Foot Adjustments		٩			O	200.00
201.00 Negative Cost Centers	0	o	c	ol ol	0	201.00
202.00 TOTAL (sum lines 118 through 201)	1, 175, 809	951, 175	436, 089	440, 464	278, 845	
					•	

Heal th	Financial Systems	FAYETTE COUNT	Y HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der CC		eriod: rom 07/01/2022 o 06/30/2023	Worksheet B Part I Date/Time Pre 11/29/2023 3:	pared: 06 pm
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		15. 00	16. 00	24.00	25. 00	26. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00 7. 00 7. 01 7. 02	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT HOSP ONLY 00702 OPERATION OF PLANT ANNEX ONLY						1. 00 2. 00 4. 00 5. 00 7. 00 7. 01 7. 02
15.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETRIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	700, 930 0	1, 052, 234				8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	1,002,201				10.00
30. 00 31. 00 44. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04400 SKILLED NURSING FACILITY	0 0 0	43, 023 0 20, 852	4, 529, 369 0 5, 606, 876	0 0 0	4, 529, 369 0 5, 606, 876	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	43, 729	2, 452, 978	0	2, 452, 978	
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	1
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	268, 895 14, 463	2, 435, 463 495, 883	0	2, 435, 463 495, 883	1
60.00	06000 LABORATORY		238, 392	4, 606, 365	ő	4, 606, 365	1
65.00	06500 RESPIRATORY THERAPY	o	21, 590	643, 876	o	643, 876	1
66.00	06600 PHYSI CAL THERAPY	0	37, 593	1, 327, 634	0	1, 327, 634	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	7, 072	195, 923	0	195, 923	1
	06800 SPEECH PATHOLOGY	0	2, 237	167, 030	0	167, 030	1
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	29, 370	378, 015	0	378, 015	1
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	700, 930	12, 546 99, 020	502, 671 3, 384, 118	0	502, 671 3, 384, 118	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	700, 730	99, 020	3, 304, 110	o	3, 304, 110	
,,,,	OUTPATIENT SERVICE COST CENTERS	91	<u> </u>	<u> </u>	<u> </u>		1
88.00	08800 RURAL HEALTH CLINIC	0	20, 831	1, 759, 870	0	1, 759, 870	88.00
88. 01	08801 RURAL HEALTH CLINIC II	0	5, 909	345, 509	0	345, 509	
90.00	09000 CLI NI C	0	19, 158	743, 153	0	743, 153	
	09002 WOUND CARE	0	6, 503	409, 668	0	409, 668	1
90. 02 90. 03	O9003 PAI N MANAGEMENT O9001 NEUROLOGY	0	493	104, 541 0	0	104, 541 0	1
	09004 FAMI LY MEDI CI NE		1, 504	598, 212	0	598, 212	
90. 05	09005 SURGERY		6, 201	732, 481	ő	732, 481	1
90.06	09006 RHEUMATOLOGY	Ö	795	89, 243	Ō	89, 243	
90. 07	09007 PULMONOLOGY	0	1, 464	83, 627	0	83, 627	90.07
	04950 FAMILY MEDICINE - NP	0	2, 193	69, 448	0	69, 448	
90.09	09008 OP NURSI NG SERVI CE	0	10, 403	229, 990	0	229, 990	1
	O9009 ENDDOCRI NOLOGY O9100 EMERGENCY	0	1, 176 136, 822	62, 456 5, 118, 318	0	62, 456 5, 118, 318	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		130, 622	3, 110, 310	0	3, 110, 310	92.00
72.00	OTHER REIMBURSABLE COST CENTERS				<u></u>		72.00
	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS	T T					
113. 00 118. 00	, ,	700, 930	1, 052, 234	37, 072, 717	0	37, 072, 717	113. 00 118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	ol	8, 411	ol	Ω //11	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES		0	1, 638, 222	ő	1, 638, 222	1
	19201 FAYETTE COUNTY ANNEX	o o	ol	162	Ö		192. 01
192.02	19202 PUBLIC RELATIONS	O	ō	0	Ō	0	192. 02
	19203 PERSONAL LAUNDRY	0	0	24, 114	o		192. 03
	19204 6TH STREET HOURSE	0	0	5, 329	0		192.04
200.00	, ,		_	0	0		200.00
201. 00 202. 00	9	700, 930	0 1, 052, 234	0 38, 748, 955	0	0 38, 748, 955	201.00
202.00	TIVIAL (Sum Times 110 through 201)	100, 730	1, 002, 234	30, 740, 733	٥Į	30, 740, 733	₁ 202.00

| Peri od: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1346

			То	06/30/2023	Date/Time Pre 11/29/2023 3:	
		CAPI TAL REL	ATED COSTS		11/24/2023 3.	OO piii
Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	Assigned New Capital	FLXT	EQUI P		BENEFITS DEPARTMENT	
	Related Costs				DELAKTMENT	
	0	1.00	2.00	2A	4. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00 OO200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT	0	756	1, 895	2, 651	2, 651	2. 00 4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	0	15, 134	342, 741	357, 875	2, 031	5.00
7. 00 00700 OPERATION OF PLANT	Ö	75, 770		110, 731	61	7. 00
7. 01 00701 OPERATION OF PLANT HOSP ONLY	0	0	0	0	0	7. 01
7.02 00702 OPERATION OF PLANT ANNEX ONLY	0	0	0	o	0	7. 02
8. 00 00800 LAUNDRY & LINEN SERVICE	0	5, 005	12, 187	17, 192	25	8. 00
9. 00 00900 HOUSEKEEPI NG	0	2, 325	4, 569	6, 894	95	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0	4, 639 2, 736	19, 495 11, 498	24, 134 14, 234	48 28	10. 00 11. 00
13.00 01300 NURSI NG ADMINI STRATION		2, 730 1, 226	11, 490	1, 226	38	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	Ö	1, 655		1, 655	13	14. 00
15. 00 01500 PHARMACY	O	1, 503	18, 135	19, 638	39	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	1, 323	12, 012	13, 335	78	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS		44 00-	44.00/	0, 000	107	
30. 00 03000 ADULTS & PEDI ATRI CS	0	11, 897	14, 986	26, 883	197	30.00
31.00 03100 INTENSIVE CARE UNIT 44.00 04400 SKILLED NURSING FACILITY	0	41, 537	0 11, 807	53, 344	0 294	31. 00 44. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	41, 557	11,007	33, 344	274	44.00
50. 00 05000 OPERATI NG ROOM	0	7, 658	339, 224	346, 882	107	50.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	4, 653	169, 628	174, 281	77	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	1, 070	12, 678	13, 748	18	55.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	6, 748 2, 087	83, 558 16, 146	90, 306	154 42	60. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY		4, 213	1, 286	18, 233 5, 499	108	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	l ő	285	0	285	17	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	16	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	O	o	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0	0	0	0	77. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	0	2, 884	2, 884	156	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	l ő	Ö	2,004	2, 004	26	88. 01
90. 00 09000 CLI NI C	0	2, 717	2, 630	5, 347	0	90.00
90. 01 09002 WOUND CARE	o	4, 472	0	4, 472	11	90. 01
90. 02 09003 PAI N MANAGEMENT	0	788	364	1, 152	7	90. 02
90. 03 09001 NEUROLOGY	0	0	0	0	0	90.03
90. 04 09004 FAMI LY MEDI CI NE 90. 05 09005 SURGERY	0	1, 941 2, 008	1, 319 842	3, 260 2, 850	85 177	90. 04 90. 05
90. 06 09006 RHEUMATOLOGY		377	350	727	7	
90. 07 09007 PULMONOLOGY	o	377	321	698	7	90. 07
90.08 04950 FAMILY MEDICINE - NP	0	681	0	681	24	90. 08
90. 09 09008 OP NURSING SERVICE	0	1, 231	0	1, 231	17	90. 09
90. 10 09009 ENDDOCRI NOLOGY	0	0	298	298	6	90. 10
91. 00 09100 EMERGENCY	0	4, 584	16, 666	21, 250	251	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				U		92.00
95. 00 09500 AMBULANCE SERVI CES	0	0	0	o	0	95.00
102.00 10200 OPI OI D TREATMENT PROGRAM	Ö	Ö		o		102.00
SPECIAL PURPOSE COST CENTERS	•					
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	211, 396	1, 132, 480	1, 343, 876	2, 510	118. 00
NONREI MBURSABLE COST CENTERS		7.0		7.0		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	763 5, 473	16 272	763 21, 745		190. 00 192. 00
192.00 19200 PHTSICIANS PRIVATE OFFICES	0	3, 473 0	16, 272	21, 743		192.00
192. 02 19202 PUBLIC RELATIONS		0		0		192.01
192. 03 19203 PERSONAL LAUNDRY		Ö	O	o		192. 03
192.04 19204 6TH STREET HOURSE	0	0	1, 369	1, 369		192. 04
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		017 (00	1 150 101	1 247 750		201.00
202.00 TOTAL (sum lines 118 through 201)	0	217, 632	1, 150, 121	1, 367, 753	2, 651	202. 00

Provider CCN: 14-1346

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2022 Part II
To 06/30/2023 Date/Time Prepared:
11/29/2023 3:06 pm

				'	0 00/30/2023	11/29/2023 3:	
	Cost Center Description	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT HOSP	OPERATION OF PLANT ANNEX	LAUNDRY & LINEN SERVICE	
		5. 00	7. 00	7. 01	ONLY 7. 02	8. 00	
G	SENERAL SERVICE COST CENTERS	3.00	7.00	7.01	7.02	0.00	
1.00 0 2.00 0 4.00 0	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	358, 156					1. 00 2. 00 4. 00 5. 00
7. 00 0 7. 01 0	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT HOSP ONLY 00702 OPERATION OF PLANT ANNEX ONLY	10, 251 10, 638	121, 043 0 0	10, 638	0		7. 00 7. 01 7. 02
8. 00 0 9. 00 0	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY	2, 891 10, 100 7, 523	5, 060 2, 350 4, 690	455 211 422	0	25, 623 2, 432 169	8. 00 9. 00 10. 00
13.00 0	01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	3, 283 3, 680 2, 063	2, 765 1, 239 1, 674	249 111 150	0 0	100 0 0	11. 00 13. 00 14. 00
15. 00 0 16. 00 0	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS	5, 992 9, 124	1, 519 1, 338	137 120	0	0	15. 00 16. 00
31.00 0	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04400 SKILLED NURSING FACILITY	32, 987 0 31, 219	12, 027 0 41, 990	1, 082 0 3, 776		0	30. 00 31. 00 44. 00
	NCILLARY SERVICE COST CENTERS	10.70	7.740			4 005	FO 00
53. 00 0 54. 00 0	05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	18, 796 0 18, 505	7, 742 0 4, 703	696 0 423	0 0	1, 235 0 154	50. 00 53. 00 54. 00
60. 00 0 65. 00 0	5500 RADI OLOGY-THERAPEUTI C 6000 LABORATORY 6500 RESPI RATORY THERAPY	4, 097 38, 024 5, 059	1, 082 6, 821 2, 109		0	37 0 62	55. 00 60. 00 65. 00
67. 00 0 68. 00 0	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	10, 626 1, 669 1, 523	4, 259 288 0	383 26 0		1, 141 0 0	66. 00 67. 00 68. 00
72. 00 0 73. 00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	2, 151 3, 024 23, 886	0 0			0	71. 00 72. 00 73. 00
	07700 ALLOGENEIC HSCT ACQUISITION DUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	77. 00
88. 00 0	08800 RURAL HEALTH CLINIC	16, 074	0	0		0	88. 00
	08801 RURAL HEALTH CLINIC II	3, 139 6, 210	0 2, 747	0		0	88. 01 90. 00
	09002 WOUND CARE	2, 528	4, 520	407	0	0	90.00
1	09003 PAIN MANAGEMENT	750	797	72	0	0	90.02
1	09001 NEUROLOGY	0 4, 995	1 043	0	0	0	90. 03 90. 04
	09004 FAMI LY MEDI CI NE 09005 SURGERY	6, 175	1, 962 2, 030	176 183		0	90.04
1	09006 RHEUMATOLOGY	716	382	34	0	0	90.06
	09007 PULMONOLOGY	658	382	34	0	0	90.07
	04950 FAMILY MEDICINE - NP 09008 OP NURSING SERVICE	439 1, 700	688 1, 245		0	0	90. 08 90. 09
	09009 ENDDOCRI NOLOGY	566	0	0		0	90. 10
	09100 EMERGENCY	42, 397	4, 634	417	0	2, 540	91.00
0	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0	0	0	0	92. 00 95. 00
102. 00 <u>1</u> S	0200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	o	0				102. 00
	1300 INTEREST EXPENSE	242 450	101 040	10 (20		24 007	113.00
118. 00 N 190. 00 1	SUBTOTALS (SUM OF LINES 1 through 117) IONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	343, 458	121, 043	10, 638		·	190.00
192. 00 1 192. 01 1	9200 PHYSICIANS' PRIVATE OFFICES 9201 FAYETTE COUNTY ANNEX	14, 641 0	0	0	_	10	192. 00 192. 01
	9202 PUBLIC RELATIONS 9203 PERSONAL LAUNDRY		0 0	0 n	0		192. 02 192. 03
192. 04 1	9204 6TH STREET HOURSE	49	0	0	0	0	192. 04
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers		^	,	_		200. 00 201. 00
202. 00	TOTAL (sum lines 118 through 201)	358, 156	121, 043	10, 638	0		

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				0 06/30/2023	11/29/2023 3:	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	оо ріп
				N N	SUPPLY	
	9. 00	10. 00	11. 00	13.00	14. 00	
GENERAL SERVICE COST CENTERS 1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT			<u> </u>	T		1. 00
2. 00 OO2OO NEW CAP REL COSTS-BLDG & FIXT						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7.00
7.01 00701 OPERATION OF PLANT HOSP ONLY						7. 01
7.02 00702 OPERATION OF PLANT ANNEX ONLY						7. 02
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG	22, 082	07.040				9.00
10. 00 01000 DI ETARY	863	37, 849	21 1/0	,		10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	509 228	0	21, 168 328			11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	308	0	369		6, 232	14.00
15. 00 01500 PHARMACY	280	0	440	1	0, 232	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	246	Ö	1, 300		0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS			,			
30. 00 03000 ADULTS & PEDIATRICS	2, 214	10, 524	3, 225	2, 817	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	C		0	31.00
44.00 O4400 SKILLED NURSING FACILITY	7, 733	27, 325	5, 763	0	0	44.00
ANCILLARY SERVICE COST CENTERS	4 405			4 500		
50. 00 05000 OPERATING ROOM	1, 425	0	1, 744	1	0	50.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1 210		0	53. 00 54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	866 199	0	1, 318 31 <i>6</i>	1	0	55. 00
60. 00 06000 LABORATORY	1, 256	0	2, 838		0	60.00
65. 00 06500 RESPIRATORY THERAPY	388	0	652	1	0	65.00
66. 00 06600 PHYSI CAL THERAPY	784	0	C	1	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	53	0	C	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	C	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	2, 590	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C	0	3, 642	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS 77.00 O7700 ALLOGENEIC HSCT ACQUISITION	0	0		1	0	73. 00 77. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	l O	U		0	U	77.00
88. 00 08800 RURAL HEALTH CLINIC	0	0		ol ol	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	o	0	d		0	88. 01
90. 00 09000 CLI NI C	506	0	C	0	0	90.00
90. 01 09002 WOUND CARE	832	0	C	0	0	90. 01
90. 02 09003 PAI N MANAGEMENT	147	0	C	0	0	90.02
90. 03 09001 NEUROLOGY	0	0	C	0	0	90. 03
90. 04 09004 FAMI LY MEDI CI NE	361	0			0	90.04
90. 05 09005 SURGERY 90. 06 09006 RHEUMATOLOGY	374 70	0			0	90. 05 90. 06
90. 07 09007 PULMONOLOGY	70	0			0	90.00
90. 08 04950 FAMILY MEDICINE - NP	127	Ö			0	90. 08
90. 09 09008 OP NURSING SERVICE	229	0	Ċ	0	0	90.09
90. 10 09009 ENDDOCRI NOLOGY	0	0	C	0	0	90. 10
91. 00 09100 EMERGENCY	853	0	2, 875	2, 510	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS		٥		J ol	0	05 00
95. 00 09500 AMBULANCE SERVICES	0	0			0	95.00
102. 00 10200 OPI OLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	l ol	U		ıl U	U	102. 00
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	20, 921	37, 849	21, 168	6, 850	6, 232	118. 00
NONREI MBURSABLE COST CENTERS		,	,	,		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	142	0	C	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 019	0	C	0		192. 00
192. 01 19201 FAYETTE COUNTY ANNEX	0	0	(0		192. 01
192. 02 19202 PUBLI C RELATIONS	0	0				192.02
192. 03 19203 PERSONAL LAUNDRY		0				192.03
192.04 19204 6TH STREET HOURSE 200.00 Cross Foot Adjustments	ا	O	(0		192. 04 200. 00
201.00 Regative Cost Centers		0	,			200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	22, 082	37, 849	21, 168	6, 850		201.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		3.7317	2.,100	3, 500	0, 202	

ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 14-1346 Peri od:		Worksheet B				
						From 07/01/2022 To 06/30/2023	Part II Date/Time Pre	pared·
							11/29/2023 3:	06 pm
		Cost Center Description	PHARMACY	MEDI CAL	Subtotal	Intern &	Total	
				RECORDS & LI BRARY		Residents Cost & Post		
				LIDIAKI		Stepdown		
						Adjustments		
			15. 00	16. 00	24. 00	25. 00	26. 00	
4 00		AL SERVICE COST CENTERS				1		1 00
1. 00 2. 00		NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP	+					1. 00 2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7. 00		OPERATION OF PLANT						7. 00
7. 01	1	OPERATION OF PLANT HOSP ONLY						7. 01
7. 02 8. 00		OPERATION OF PLANT ANNEX ONLY LAUNDRY & LINEN SERVICE	+					7. 02 8. 00
9. 00		HOUSEKEEPI NG						9.00
10.00		DI ETARY						10.00
11. 00		CAFETERI A						11.00
13.00		NURSI NG ADMI NI STRATI ON						13.00
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY	28, 045					14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	26, 045	25, 541				16.00
10.00		I ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	20,011				10.00
30.00		ADULTS & PEDIATRICS	0	1, 042	96, 788	0	96, 788	30.00
31.00	1	INTENSIVE CARE UNIT	0	0	(0	31.00
44. 00		SKILLED NURSING FACILITY	0	505	184, 386	5 0	184, 386	44.00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	O	1, 060	381, 210	ol	381, 210	50.00
53. 00	1	ANESTHESI OLOGY	0	0	301, 210		0	1
54.00		RADI OLOGY-DI AGNOSTI C	0	6, 563	206, 890		206, 890	•
55. 00	1	RADI OLOGY-THERAPEUTI C	0	350	19, 944		19, 944	•
60.00	1	LABORATORY THERABY	0	5, 776	145, 788		145, 788	1
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	0	523 911	27, 258 23, 71		27, 258 23, 711	1
67. 00		OCCUPATIONAL THERAPY	0	171	2, 509		2, 509	
68. 00		SPEECH PATHOLOGY	O	54	1, 593		1, 593	1
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	О	712	5, 453	o o	5, 453	71.00
72. 00		IMPL. DEV. CHARGED TO PATIENT	0	304	6, 970		6, 970	
73. 00 77. 00		DRUGS CHARGED TO PATIENTS ALLOGENEIC HSCT ACQUISITION	28, 045 0	2, 399 0	54, 330 (54, 330 0	73. 00 77. 00
77.00		TIENT SERVICE COST CENTERS	U _L	0		<u> </u>	0	77.00
88. 00		RURAL HEALTH CLINIC	0	505	19, 619	9 0	19, 619	88. 00
88. 01		RURAL HEALTH CLINIC II	0	143	3, 308		3, 308	
90.00		CLINIC	0	464	15, 274		15, 274	
90. 01 90. 02		WOUND CARE PAIN MANAGEMENT	0	158 12	12, 928 2, 937		12, 928 2, 937	
90. 02		NEUROLOGY	0	0	2, 73		2, 737	1
90. 04		FAMILY MEDICINE	O	36	10, 875	o o	10, 875	
		SURGERY	0	150				90.05
	1	RHEUMATOLOGY	0	19			1, 955	
90. 07 90. 08		PULMONOLOGY FAMILY MEDICINE - NP	0	35 53	1, 884		1, 884 2, 074	•
90.08		OP NURSING SERVICE	0	252	2, 074 4, 786		4, 786	•
90. 10		ENDDOCRI NOLOGY	0	29			899	•
91.00		EMERGENCY	0	3, 315			81, 042	•
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
05 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	0	0	(o o	0	05 00
		OPIOID TREATMENT PROGRAM	0	0				95. 00 102. 00
.02.00		AL PURPOSE COST CENTERS	<u> </u>			<u>, </u>		1.02.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28, 045	25, 541	1, 326, 350	0	1, 326, 350	118.00
100.00		I MBURSABLE COST CENTERS			011		012	100 00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0	0	913 37, 549		37, 549	190.00
	1	FAYETTE COUNTY ANNEX	0	0	37, 54			192.00
		PUBLI C RELATIONS	O	0	(-		192. 02
		PERSONAL LAUNDRY	0	0	1, 513			192. 03
		6TH STREET HOURSE	0	0	1, 418			192.04
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers		^	(200. 00 201. 00
201.00		TOTAL (sum lines 118 through 201)	28, 045	25, 541	1, 367, 753	-	1, 367, 753	
30	1		_==, = .0	, - · ·	, , , , , , , ,	, 9	, 221, 100	

From 07/01/2022 06/30/2023 Date/Time Prepared: 11/29/2023 3:06 pm CAPITAL RELATED COSTS NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description **BENEFLTS** E & GENERAL FLXT **FOULP** n (SQUARE (DOLLAR DEPARTMENT (ACCUM. FEET) VALUE) (GROSS COST) SALARIES) 1. 00 2.00 4.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 129, 754 1 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 647, 657 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 16, 245, 380 4.00 451 1,067 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 193, 005 1, 726, 800 9.023 -3, 864, 174 34, 884, 781 5.00 7.00 00700 OPERATION OF PLANT 45, 174 19,687 374, 135 998, 466 7.00 7.01 00701 OPERATION OF PLANT HOSP ONLY 0 1,036,091 7.01 0 00702 OPERATION OF PLANT ANNEX ONLY 0 7 02 0 0 7 02 0 00800 LAUNDRY & LINEN SERVICE 0 8.00 2,984 6,863 152, 813 281, 596 8.00 9.00 00900 HOUSEKEEPI NG 1, 386 2, 573 581, 138 0 983, 690 9.00 10.00 01000 DI ETARY 2,766 10, 978 295, 886 0 0 732, 733 10.00 01100 CAFFTERI A 319, 726 11 00 174, 662 11 00 1.631 6, 475 01300 NURSING ADMINISTRATION 13.00 731 C 234, 732 358, 436 13.00 01400 CENTRAL SERVICES & SUPPLY 987 78, 512 0 200, 965 14.00 14.00 ol 01500 PHARMACY 896 10, 212 239, 812 15.00 583, 621 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 789 6,764 475, 854 0 888, 631 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 3, 212, 906 30.00 03000 ADULTS & PEDIATRICS 7, 093 0 30.00 8, 439 1, 210, 857 03100 INTENSIVE CARE UNIT 31 00 0 0 31 00 04400 SKILLED NURSING FACILITY 44.00 24, 765 6,649 1, 780, 026 0 3, 040, 689 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 566 191, 024 657. 517 0 1.830.753 50.00 05300 ANESTHESI OLOGY 0 53 00 0 0 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2,774 95, 521 471, 580 0 1, 802, 351 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 638 7, 139 113, 225 399,079 55.00 0 06000 LABORATORY 3, 703, 527 60.00 4.023 47.053 944.872 60.00 9, 092 06500 RESPIRATORY THERAPY 65.00 1.244 259, 160 492, 758 65 00 o 66.00 06600 PHYSI CAL THERAPY 2,512 724 661, 313 1,034,993 66.00 06700 OCCUPATI ONAL THERAPY 0 67 00 170 105, 315 162, 572 67 00 0 06800 SPEECH PATHOLOGY 0 96, 704 68.00 0 148, 359 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 0 C 0 209, 530 71 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 294, 557 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS o 73.00 0 C 0 2, 326, 465 73.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 1,624 955, 801 0 1, 565, 616 88.00 88.01 08801 RURAL HEALTH CLINIC II 0 o 305, 734 161, 703 88.01 90 00 09000 CLINIC 1.620 1, 481 0 604, 895 0 90 00 90.01 09002 WOUND CARE 2,666 67,839 0 246, 184 90.01 90.02 09003 PAIN MANAGEMENT 470 205 45, 923 0 73,084 90.02 0 09001 NEUROLOGY 90.03 90.03 0 09004 FAMILY MEDICINE 90.04 1, 157 743 518, 501 486, 524 90.04 90.05 09005 SURGERY 1, 197 474 1,088,095 0 601, 422 90.05 09006 RHEUMATOLOGY 197 44, 021 0 0 69, 772 90.06 90.06 225 09007 PULMONOLOGY 90 07 225 181 40.488 64, 114 90 07 90.08 04950 FAMILY MEDICINE - NP 406 C 147, 937 42,764 90.08 09008 OP NURSING SERVICE 0 90.09 734 101, 525 165, 538 90.09 ol 09009 ENDDOCRI NOLOGY 90.10 37, 499 55, 169 90.10 168 91.00 09100 EMERGENCY 2,733 9, 385 1, 538, 514 0 4, 129, 933 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 n O 0 n 95.00 102.00 10200 OPIOID TREATMENT PROGRAM C 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 637, 723 15, 382, 759 33, 453, 243 118. 00 126, 036 -3, 864, 174 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 763 190. 00 455 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 3.263 9.163 862, 621 0 1, 425, 977 192. 00 192. 01 19201 FAYETTE COUNTY ANNEX 0 0 192.01 0 C 192. 02 19202 PUBLIC RELATIONS 0 0 0 0 192.02 C 192. 03 19203 PERSONAL LAUNDRY 0 0 0 192.03 192. 04 19204 6TH STREET HOURSE 0 0 4, 798 192, 04 771 200.00 Cross Foot Adjustments 200 00

217, 632

1.677266

1, 150, 121

1. 775818

7, 205, 841

0.443562

201.00

3, 864, 174 202. 00

0. 110770 203. 00

Negative Cost Centers

Part I)

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part I)

201.00

202.00

203.00

Heal th F	Financial Systems	FAYETTE COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COST AL	LOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1		
					From 07/01/2022 Fo 06/30/2023			
		CAPI TAL REL	ATED COSTS					
	Cost Center Description	NEW BLDG &	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Reconciliatio	ADMINISTRATIV E & GENERAL		
		(SQUARE FEET)	(DOLLAR VALUE)	DEPARTMENT (GROSS	"	(ACCUM.		
		I LL I)	VALUE	SALARI ES)		0031)		
		1. 00	2.00	4. 00	5A	5. 00		
204. 00	Cost to be allocated (per Wkst. B, Part II)			2, 65	1	358, 156	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00016	3	0. 010267	205. 00	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS FAYETTE COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 14-1346 Peri od: Worksheet B-1 From 07/01/2022 To 06/30/2023 OPERATION OF OPERATION OF OPERATION OF LAUNDRY & HOUSEKEEPING Cost Center Description

	Cost Center Description	OPERATION OF PLANT (SQ FT)	PLANT HOSP ONLY	PLANT ANNEX ONLY	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPING (SQUARE FEET)	
			(SQ FT)	(SQUARE FEET)	LAUNDRY)		
	GENERAL SERVICE COST CENTERS	7. 00	7. 01	7.02	8. 00	9. 00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	71, 388					5. 00 7. 00
7. 00	00701 OPERATION OF PLANT HOSP ONLY	0	69, 768				7.00
7. 02	00702 OPERATION OF PLANT ANNEX ONLY	0	0	0			7. 02
8. 00	00800 LAUNDRY & LINEN SERVICE	2, 984			402, 993		8. 00
9.00	00900 HOUSEKEEPI NG	1, 386	l '	1	38, 250		9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	2, 766 1, 631	2, 766 1, 631	1	2, 664 1, 572	2, 766 1, 631	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	731	731	1	0	731	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	987	987	0	0	987	14.00
15.00	01500 PHARMACY	896	l e	1	0	896	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	789	789	0	0	789	16. 00
30. 00	03000 ADULTS & PEDIATRICS	7, 093	7, 093	0	59, 613	7, 093	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44. 00	04400 SKILLED NURSING FACILITY	24, 765	24, 765	0	195, 597	24, 765	44.00
FO 00	ANCILLARY SERVICE COST CENTERS	1 4 5//	4 5//	1 0	10 400	4 5//	
50. 00 53. 00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	4, 566 0	4, 566 0	1	19, 428	4, 566 0	50. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 774	2, 774	_	2, 415	2, 774	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	638	638		580	638	55.00
60.00	06000 LABORATORY	4, 023	4, 023	1	0	4, 023	60.00
65.00	06500 RESPI RATORY THERAPY	1, 244		1	976	1, 244	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	2, 512 170			17, 944	2, 512 170	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	170		0	0	68.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö	Ö	0	Ö	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88. 01
90.00	09000 CLI NI C	1, 620	ł	_	0	1, 620	90.00
90. 01	09002 WOUND CARE	2, 666	l '	1	0	2, 666	1
90. 02 90. 03	09003 PAI N MANAGEMENT 09001 NEUROLOGY	470	470	0	0	470 0	90. 02 90. 03
90. 03	09004 FAMILY MEDICINE	1, 157	1, 157	0	0	1, 157	90.03
90.05	09005 SURGERY	1, 197			0	1, 197	90. 05
90.06	09006 RHEUMATOLOGY	225			0	225	90.06
90.07	09007 PULMONOLOGY	225	ŀ	1	0	225	90.07
90. 08 90. 09	04950 FAMILY MEDICINE - NP 09008 OP NURSING SERVICE	406 734	406 734	1	0	406 734	90. 08 90. 09
	09009 ENDDOCRI NOLOGY	0	0	Ö	0	0	
	09100 EMERGENCY	2, 733	2, 733	0	39, 948		
92.00							92.00
05 00	OTHER REIMBURSABLE COST CENTERS			1 0	0	0	95. 00
	09500 AMBULANCE SERVICES 10200 OPIOID TREATMENT PROGRAM	0	l .				102.00
102.0	SPECIAL PURPOSE COST CENTERS				9		102.00
	11300 INTEREST EXPENSE						113.00
118. 00		71, 388	69, 768	0	378, 987	67, 018	118. 00
100 0	NONREIMBURSABLE COST CENTERS D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	155	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	1	0	50		192.00
	1 19201 FAYETTE COUNTY ANNEX	Ö	Ö	Ö	160	· ·	192. 01
	2 19202 PUBLIC RELATIONS	0	0	0	0		192. 02
	3 19203 PERSONAL LAUNDRY	0	0	0	23, 796		192. 03
	4 19204 6TH STREET HOURSE Cross Foot Adjustments	0	0	0	0	0	192.04
200. 00 201. 00							200. 00 201. 00
202.00		1, 109, 066	1, 150, 859	0	408, 370	1, 175, 809	
	Part I)						
203.00		15. 535748	ł .	1			
204. 00	Cost to be allocated (per Wkst. B, Part II)	121, 043	10, 638	0	25, 623	22, 082	204.00
205. 00		1. 695565	0. 152477	0. 000000	0. 063582	0. 312175	205. 00

Heal th Finar	ncial Systems	FAYETTE COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1		
					rom 07/01/2022			
					To 06/30/2023			
						11/29/2023 3:	06 pm	
	Cost Center Description	OPERATION OF	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		
		PLANT	PLANT HOSP	PLANT ANNEX	LINEN SERVICE	(SQUARE		
		(SQ FT)	ONLY	ONLY	(POUNDS OF	FEET)		
			(SQ FT)	(SQUARE FEET)	LAUNDRY)			
		7. 00	7. 01	7. 02	8. 00	9. 00		
206.00	NAHE adjustment amount to be allocated						206.00	
	(per Wkst. B-2)							
207.00	NAHE unit cost multiplier (Wkst. D,						207.00	
	Parts III and IV)							

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1346 Peri od: Worksheet B-1 From 07/01/2022 06/30/2023 Date/Time Prepared: 11/29/2023 3:06 pm Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI O SERVICES & (MEALS (NUMBER OF (COSTED SERVED) FTE'S) **SUPPLY** REQUISITIONS) Ν (NUMBER OF (COSTED REQUISITIONS) FTE'S) 10.00 11.00 14.00 15.00 13.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00701 OPERATION OF PLANT HOSP ONLY 7.01 7.01 7.0200702 OPERATION OF PLANT ANNEX ONLY 7.028.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 45, 091 10.00 11.00 01100 CAFETERI A 10, 389 11.00 01300 NURSING ADMINISTRATION 3,850 13.00 0 13.00 161 01400 CENTRAL SERVICES & SUPPLY 14.00 0 181 0 504, 087 14.00 15.00 01500 PHARMACY 0 216 0 100 15.00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 16.00 16.00 638 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 12, 538 1,583 1, 583 0 0 30.00 03100 INTENSIVE CARE UNIT 0 31.00 0 31.00 C 04400 SKILLED NURSING FACILITY 32, 553 2,828 44.00 0 44.00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 856 856 0 0 50.00 05300 ANESTHESI OLOGY 53.00 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54 00 647 O 54 00 0 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 155 0 0 55.00 0 60.00 06000 LABORATORY 1, 393 0 0 60.00 0 65.00 06500 RESPIRATORY THERAPY 0 0 320 0 0 65.00 06600 PHYSI CAL THERAPY 0 66 00 0 66.00 C 0 06700 OCCUPATI ONAL THERAPY 0 67.00 C 0 0 67.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 C 0 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 209, 530 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 72 00 Ω 294, 557 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 C 0 100 73.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 0 0 88.00 08800 RURAL HEALTH CLINIC 0 0 88.01 08801 RURAL HEALTH CLINIC II 0 0 0 0 88.01 90 00 09000 CLI NI C 0 0 0 0 0 0 90 00 0 09002 WOUND CARE 0 90.01 90.01 0 0 09003 PAIN MANAGEMENT 0 90.02 Ω 0 90.02 90.03 09001 NEUROLOGY 0000000 0 0 0 0 90.03 09004 FAMILY MEDICINE 0 0 0 90.04 90.04 0 0 0 0 90.05 90.05 09005 SURGERY C 0 90.06 09006 RHEUMATOLOGY 0 0 0 90.06 90 07 09007 PULMONOLOGY O 90.07 0 04950 FAMILY MEDICINE - NP 0 90.08 90.08 C 0 09008 OP NURSING SERVICE 90 09 r 0 0 90.09 09009 ENDDOCRI NOLOGY 90.10 90.10 0 91.00 09100 EMERGENCY 1, 411 1, 411 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES C 95.00 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 10, 389 3, 850 100 118.00 118.00 45, 091 504, 087 NONREI MBURSABLE COST CENTERS 0 190, 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 192. 01 19201 FAYETTE COUNTY ANNEX 0 0 0 0 0 192. 01 0 192. 02 19202 PUBLIC RELATIONS Ω O 0 0 192.02 192. 03 19203 PERSONAL LAUNDRY 0 C 0 0 0 192.03 192. 04 19204 6TH STREET HOURSE 0 0 0 0 192.04 200.00 Cross Foot Adjustments 200.00 201 00 Negative Cost Centers 201 00 202.00 Cost to be allocated (per Wkst. B, 951, 175 436, 089 440, 464 278, 845 700, 930 202. 00 Part I)

21. 094564

37, 849

41. 976032

21, 168

114. 406234

6,850

0. 553168

6, 232

7, 009. 300000 203. 00 28, 045 204. 00

Part II)

Unit cost multiplier (Wkst. B, Part I)

Cost to be allocated (per Wkst. B,

203.00

204.00

Heal th Fi	nancial Systems	FAYETTE COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLO	OCATION - STATISTICAL BASIS				Peri od: Worksheet I		
					rom 07/01/2022 o 06/30/2023		
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
		(MEALS	(NUMBER OF	ADMI NI STRATI O	SERVICES &	(COSTED	
		SERVED)	FTE' S)	N	SUPPLY	REQUISITIONS)	
				(NUMBER OF	(COSTED		
				FTE' S)	REQUISITIONS)		
		10. 00	11. 00	13.00	14.00	15.00	
205.00	Unit cost multiplier (Wkst. B, Part	0. 839391	2. 037540	1. 779221	0. 012363	280. 450000	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

Health Financial Systems FAYETTE COUNTY HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1346 Period: From 07/01/2022 Worksheet B-1

06/30/2023 Date/Time Prepared: 11/29/2023 3:06 pm Cost Center Description MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00701 OPERATION OF PLANT HOSP ONLY 7.01 7.01 7.0200702 OPERATION OF PLANT ANNEX ONLY 7.028.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 98, 816, 281 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4, 040, 465 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 04400 SKILLED NURSING FACILITY 1, 958, 297 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 106, 817 50.00 05300 ANESTHESI OLOGY 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 25, 249, 525 54 00 05500 RADI OLOGY-THERAPEUTI C 55.00 1, 358, 253 55.00 60. 00 | 06000 | LABORATORY 22, 388, 410 60.00 65.00 06500 RESPIRATORY THERAPY 2,027,645 65.00 06600 PHYSI CAL THERAPY 66 00 3, 530, 505 66 00 06700 OCCUPATI ONAL THERAPY 67.00 664, 153 67.00 210, 124 06800 SPEECH PATHOLOGY 68.00 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 758, 246 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 1, 178, 230 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 9, 299, 369 73.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 1, 956, 361 88.00 08800 RURAL HEALTH CLINIC 88. 01 08801 RURAL HEALTH CLINIC II 554, 921 88.01 90.00 09000 CLI NI C 1, 799, 235 90 00 09002 WOUND CARE 90.01 610, 741 90.01 09003 PAIN MANAGEMENT 90.02 46, 258 90.02 90.03 09001 NEUROLOGY 90.03 09004 FAMILY MEDICINE 141, 243 90.04 90.04 90.05 582, 323 90.05 09005 SURGERY 90.06 09006 RHEUMATOLOGY 74, 679 90.06 90 07 09007 PULMONOLOGY 137, 492 90.07 04950 FAMILY MEDICINE - NP 90.08 205, 961 90.08 09008 OP NURSING SERVICE 90 09 977.009 90 09 90.10 09009 ENDDOCRI NOLOGY 110, 471 90.10 91.00 09100 EMERGENCY 12, 849, 548 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 102.00 10200 OPI OID TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 98, 816, 281 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 192. 01 19201 FAYETTE COUNTY ANNEX 0 192.01 0 192. 02 19202 PUBLIC RELATIONS 192. 02 192. 03 19203 PERSONAL LAUNDRY 0 192.03 192. 04 19204 6TH STREET HOURSE 0 192.04 200.00 Cross Foot Adjustments 200.00 201 00 Negative Cost Centers 201 00 202.00 Cost to be allocated (per Wkst. B, 1, 052, 234 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.010648 203.00 Cost to be allocated (per Wkst. B, 204.00 204.00 25, 541 Part II)

Heal th Finar	ncial Systems	FAYETTE COUNTY	HOSPI TAL	In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CCN: 14-1346	Peri od: From 07/01/2022 To 06/30/2023	Worksheet B-1 Date/Time Prepared: 11/29/2023 3:06 pm		
	Cost Center Description	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16. 00					
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000258			205. 00		
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)				206. 00		
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207. 00		

Health Financial Systems	FAYETTE COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 14-1346	Peri od: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/29/2023 3:	pared: 06 pm
		Title	e XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

			T: +1 -	V/V/I I I	11! +-1	11/2//2025 5.	оо рііі
			II tie	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
			, Auj .		Di Sai i Gwariec		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	4, 529, 369		4, 529, 369	0	4, 529, 369	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0		0			31.00
44. 00	04400 SKILLED NURSING FACILITY	5, 606, 876		5, 606, 876			
44.00		5, 606, 876		5, 606, 876	U	5, 606, 876	44.00
	ANCILLARY SERVICE COST CENTERS	1			ı	ı	
50.00	05000 OPERATING ROOM	2, 452, 978		2, 452, 978	0	2, 452, 978	50.00
53.00	05300 ANESTHESI OLOGY	0		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 435, 463		2, 435, 463	0	2, 435, 463	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	495, 883		495, 883		495, 883	
60.00	06000 LABORATORY	1					
		4, 606, 365		4, 606, 365		4, 606, 365	
65.00	06500 RESPI RATORY THERAPY	643, 876				643, 876	
66.00	06600 PHYSI CAL THERAPY	1, 327, 634	0	1, 327, 634	0	1, 327, 634	66.00
67.00	06700 OCCUPATI ONAL THERAPY	195, 923	0	195, 923	0	195, 923	67.00
68.00	06800 SPEECH PATHOLOGY	167, 030	0	167, 030	0	167, 030	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	378, 015		378, 015		378, 015	
72.00							
	07200 I MPL. DEV. CHARGED TO PATIENT	502, 671		502, 671		502, 671	
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 384, 118		3, 384, 118		3, 384, 118	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	1, 759, 870		1, 759, 870	0	1, 759, 870	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	345, 509		345, 509		345, 509	
90.00	09000 CLINIC	743, 153		743, 153		743, 153	
90. 01	09002 WOUND CARE	409, 668		409, 668		409, 668	
90. 02	09003 PAIN MANAGEMENT	104, 541		104, 541	0	104, 541	90. 02
90. 03	09001 NEUROLOGY	0		0	0	0	90. 03
90.04	09004 FAMILY MEDICINE	598, 212		598, 212	0	598, 212	90.04
90.05	09005 SURGERY	732, 481		732, 481		732, 481	90.05
90.06	09006 RHEUMATOLOGY	89, 243		89, 243		89, 243	
90. 07	09007 PULMONOLOGY	83, 627		83, 627		83, 627	
90. 08	04950 FAMILY MEDICINE - NP	69, 448		69, 448		69, 448	
90.09	09008 OP NURSING SERVICE	229, 990		229, 990	0	229, 990	
90. 10	09009 ENDDOCRI NOLOGY	62, 456		62, 456	0	62, 456	90. 10
91.00	09100 EMERGENCY	5, 118, 318		5, 118, 318	0	5, 118, 318	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	908, 959		908, 959		908, 959	
72.00	OTHER REIMBURSABLE COST CENTERS	700, 737		700, 737		700, 737	72.00
05 00			I				05.00
95.00	09500 AMBULANCE SERVICES	0		0			
102.00	10200 OPIOID TREATMENT PROGRAM	0		0		0	102. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 NTEREST EXPENSE						113.00
200.00		37, 981, 676	0	37, 981, 676	0	37, 981, 676	
201.00	,	908, 959		908, 959		908, 959	
201.00		37, 072, 717					
202. U	Trotal (See Fristructions)	31,012,717	0	31,012,717	ı	31,012,111	12U2. UU

Health Financial Systems	FAYETTE COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1346	Period: Worksheet C
		From 07/01/2022 Part I
		To 04/20/2022 Data/Time Dropared

				From 07/01/2022 To 06/30/2023	Part I Date/Time Pre 11/29/2023 3:	
		Title	: XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
			+ col. 7)	Ratio	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	2, 811, 933		2, 811, 93	3		30.00
31.00 03100 INTENSIVE CARE UNIT	0			0		31.00
44.00 O4400 SKILLED NURSING FACILITY	1, 958, 297		1, 958, 29	7		44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	304, 184	3, 802, 633	4, 106, 81		0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	0	0	l .	0. 000000	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	764, 373	24, 485, 152			0.000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	30, 420	1, 327, 833	1, 358, 25	0. 365089	0.000000	55.00
60. 00 06000 LABORATORY	1, 277, 605	21, 110, 805	22, 388, 41	0. 205748	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	718, 073	1, 309, 572	2, 027, 64	5 0. 317549	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	503, 861	3, 026, 644	3, 530, 50	5 0. 376046	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	260, 368	403, 785	664, 15	3 0. 294997	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	55, 086	155, 038	210, 12	4 0. 794912	0.000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	720, 078	2, 038, 168	2, 758, 24	6 0. 137049	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	563, 054	615, 176	1, 178, 23	0. 426632	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 769, 725	7, 529, 644	9, 299, 36	9 0. 363908	0.000000	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0. 000000	0.000000	77. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	1, 956, 361	1, 956, 36	1		88. 00
88. 01 08801 RURAL HEALTH CLINIC II	O	554, 921	554, 92	1		88. 01
90. 00 09000 CLI NI C	o	1, 799, 235	1, 799, 23	5 0. 413038	0.000000	90.00
90. 01 09002 WOUND CARE	o	610, 741	610, 74	1 0. 670772	0.000000	90. 01
90. 02 09003 PAIN MANAGEMENT	o	46, 258	46, 25	8 2. 259955	0.000000	90.02
90. 03 09001 NEUROLOGY	o	0		0. 000000	0.000000	90.03
90. 04 09004 FAMILY MEDICINE	o	141, 243	141, 24	3 4. 235339	0.000000	90.04
90. 05 09005 SURGERY	o	582, 323	582, 32	3 1. 257860	0.000000	90.05
90. 06 09006 RHEUMATOLOGY	O	74, 679	74, 67	9 1. 195021	0.000000	90.06
90. 07 09007 PULMONOLOGY	O	137, 492	137, 49	2 0. 608232	0.000000	90. 07
90.08 04950 FAMILY MEDICINE - NP	O	205, 961	205, 96	0. 337190	0.000000	90.08
90. 09 09008 OP NURSING SERVICE	O	977, 009	977, 00	9 0. 235402	0.000000	90.09
90. 10 09009 ENDDOCRI NOLOGY	0	110, 471	110, 47	1 0. 565361	0.000000	90. 10
91. 00 09100 EMERGENCY	o	12, 849, 548	12, 849, 54		0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	100,000	1, 128, 532	1, 228, 53	2 0. 739874	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS	, · · ,					
95. 00 09500 AMBULANCE SERVI CES	0	0		0. 000000	0.000000	95.00
102.00 10200 OPIOID TREATMENT PROGRAM	o	0		o		102.00
SPECIAL PURPOSE COST CENTERS			·	<u> </u>		
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	11, 837, 057	86, 979, 224	98, 816, 28	1		200.00
201.00 Less Observation Beds		,,				201.00
202.00 Total (see instructions)	11, 837, 057	86, 979, 224	98, 816, 28	1		202. 00

Health Financial Systems	FAYETTE COUNTY HOSPITAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 1	From 07/01/2022	Worksheet C Part I Date/Time Prepared: 11/29/2023 3:06 pm

			10 06/30/2023	11/29/2023 3:	
		Title XVIII	Hospi tal	Cost	оо рііі
Cost Center Description	PPS Inpatient				
'	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
44.00 04400 SKILLED NURSING FACILITY					44.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 597294				50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 096456				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 365089				55.00
60. 00 06000 LABORATORY	0. 205748				60.00
65. 00 06500 RESPIRATORY THERAPY	0. 317549				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 376046				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 294997				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 794912				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 137049				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 426632				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 363908				73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77.00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC					88. 00
88.01 08801 RURAL HEALTH CLINIC II					88. 01
90. 00 09000 CLI NI C	0. 413038				90.00
90. 01 09002 WOUND CARE	0. 670772				90. 01
90. 02 09003 PAIN MANAGEMENT	2. 259955				90. 02
90. 03 09001 NEUROLOGY	0. 000000				90.03
90. 04 09004 FAMILY MEDICINE	4. 235339				90.04
90. 05 09005 SURGERY	1. 257860				90.05
90. 06 09006 RHEUMATOLOGY	1. 195021				90.06
90. 07 09007 PULMONOLOGY	0. 608232				90.07
90. 08 04950 FAMILY MEDICINE - NP	0. 337190				90.08
90. 09 09008 OP NURSING SERVICE	0. 235402				90.09
90. 10 09009 ENDDOCRI NOLOGY	0. 565361				90. 10
91. 00 09100 EMERGENCY	0. 398327				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 739874				92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
102.00 10200 OPIOID TREATMENT PROGRAM					102.00
SPECIAL PURPOSE COST CENTERS					1
113. 00 11300 NTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
1	1				

Health Financial Systems	FAYETTE COUNTY HOSPITAL	In Lieu of	Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1346	From 07/01/2022 Par To 06/30/2023 Dat	ksheet C t I e/Time Prepared: 29/2023 3:06 pm

					To 06/30/2023	Date/Time Pre 11/29/2023 3:	pared: 06 pm
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	(from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		col. 26)	0.00	2.00	4.00	F 00	
	LANDATI ENT. DOUTLAND OFFICE COOT OFFITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				_ _		
30. 00	03000 ADULTS & PEDI ATRI CS	4, 529, 369		4, 529, 36		0	30.00
31.00	03100 INTENSIVE CARE UNIT	0			0	0	
44. 00	04400 SKILLED NURSING FACILITY	5, 606, 876		5, 606, 87	5 0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 452, 978		2, 452, 97		0	50.00
53.00	05300 ANESTHESI OLOGY	0			0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 435, 463		2, 435, 46		0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	495, 883		495, 88	3 0	0	55.00
60.00	06000 LABORATORY	4, 606, 365		4, 606, 36	5 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	643, 876	0	643, 87	6 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 327, 634	0	1, 327, 63	4 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	195, 923	0	195, 92	3 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	167, 030	0	167, 03	0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	378, 015		378, 01	5 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	502, 671		502, 67	1 ol	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 384, 118		3, 384, 11	3 0	0	73. 00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	l ol			ol ol	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>			<u>'</u>		1
88. 00	08800 RURAL HEALTH CLINIC	1, 759, 870		1, 759, 87	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	345, 509		345, 50		0	88. 01
90.00	09000 CLI NI C	743, 153		743, 15		0	90.00
90. 01	09002 WOUND CARE	409, 668		409, 66		0	90. 01
90. 02	09003 PAIN MANAGEMENT	104, 541		104, 54		0	90.02
90. 03	09001 NEUROLOGY	0				0	90.03
90. 04	09004 FAMILY MEDICINE	598, 212		598, 21	-	0	90. 04
90. 05	09005 SURGERY	732, 481		732, 48		0	90.05
90.06	09006 RHEUMATOLOGY	89, 243		89, 24		0	90.06
90. 07	09007 PULMONOLOGY	83, 627		83, 62		0	90.07
90. 08	04950 FAMILY MEDICINE - NP	69, 448		69, 44		0	90.08
90.09	09008 OP NURSING SERVICE	229, 990		229, 99		0	90.09
90. 10	09009 ENDDOCRI NOLOGY	62, 456		62, 45		0	90.10
91. 00	09100 EMERGENCY	5, 118, 318		5, 118, 31		0	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	908, 959		908, 95		0	91.00
92.00	OTHER REIMBURSABLE COST CENTERS	900, 939		900, 93	7	U	92.00
05 00	09500 AMBULANCE SERVICES	O			ol lo	0	05 00
	1	1					
102.00	10200 OPI OI D TREATMENT PROGRAM	0			0	0	102.00
110 00	SPECIAL PURPOSE COST CENTERS						1112 00
	11300 I NTEREST EXPENSE	07.004.77	_	07.004.77	,		113.00
200.00		37, 981, 676	0				200.00
201.00		908, 959	_	908, 95			201.00
202.00	Total (see instructions)	37, 072, 717	0	37, 072, 71	7 0	0	202. 00

Health Financial Systems	FAYETTE COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1346	Period: Worksheet C
		From 07/01/2022 Part I
		To 04/20/2022 Data/Time Dropared

					o 06/30/2023	Date/Time Pre	pared: 06 pm
			Ti tl	e XIX	Hospi tal	Cost	<u> </u>
	·		Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		·		+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7.00	8. 00	9. 00	10.00	
I	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDI ATRI CS	2, 811, 933		2, 811, 933	3		30.00
	3100 INTENSIVE CARE UNIT	0					31.00
	14400 SKILLED NURSING FACILITY	1, 958, 297		1, 958, 297	7		44.00
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	304, 184	3, 802, 633	4, 106, 817		0.000000	
	5300 ANESTHESI OLOGY	0	0	1	0.00000	0. 000000	
	5400 RADI OLOGY-DI AGNOSTI C	764, 373	24, 485, 152			0. 000000	
	5500 RADI OLOGY-THERAPEUTI C	30, 420	1, 327, 833			0. 000000	1
	6000 LABORATORY	1, 277, 605	21, 110, 805			0. 000000	1
	6500 RESPI RATORY THERAPY	718, 073	1, 309, 572			0. 000000	
	6600 PHYSI CAL THERAPY	503, 861	3, 026, 644			0. 000000	
	6700 OCCUPATI ONAL THERAPY	260, 368	403, 785			0.000000	67.00
	6800 SPEECH PATHOLOGY	55, 086	155, 038	210, 124	0. 794912	0.000000	68. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	720, 078	2, 038, 168	2, 758, 246		0.000000	71.00
	7200 IMPL. DEV. CHARGED TO PATIENT	563, 054	615, 176			0.000000	
	7300 DRUGS CHARGED TO PATIENTS	1, 769, 725	7, 529, 644			0. 000000	73.00
	77700 ALLOGENEIC HSCT ACQUISITION	0	0) (0. 000000	0. 000000	77. 00
	UTPATIENT SERVICE COST CENTERS	,					
	8800 RURAL HEALTH CLINIC	0	1, 956, 361			0. 000000	
	8801 RURAL HEALTH CLINIC II	0	554, 921			0. 000000	88. 01
	9000 CLI NI C	0	1, 799, 235			0. 000000	90.00
	9002 WOUND CARE	0	610, 741			0. 000000	90. 01
	9003 PAI N MANAGEMENT	0	46, 258			0. 000000	
	99001 NEUROLOGY	0	0	1		0. 000000	90. 03
	9004 FAMILY MEDICINE	0	141, 243			0. 000000	1
	9005 SURGERY	0	582, 323			0. 000000	90.05
	99006 RHEUMATOLOGY	0	74, 679			0. 000000	
	99007 PULMONOLOGY	0	137, 492			0. 000000	
1	14950 FAMILY MEDICINE - NP	0	205, 961			0. 000000	1
	19008 OP NURSING SERVICE	0	977, 009			0. 000000	
	19009 ENDDOCRI NOLOGY	0	110, 471			0. 000000	
	19100 EMERGENCY	0	12, 849, 548			0. 000000	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	100, 000	1, 128, 532	1, 228, 532	0. 739874	0. 000000	92.00
	THER REIMBURSABLE COST CENTERS				0.000000	0.000000	05 00
	9500 AMBULANCE SERVI CES	0	0			0. 000000	
	0200 OPI OI D TREATMENT PROGRAM	0	0) ()		102.00
	PECIAL PURPOSE COST CENTERS						112 00
1	1300 INTEREST EXPENSE	11 027 057	07.070.004	00 014 001			113.00
200.00	Subtotal (see instructions)	11, 837, 057	86, 979, 224	98, 816, 281			200.00
201.00	Less Observation Beds	11 027 057	06 070 224	00 014 201			201. 00 202. 00
202. 00	Total (see instructions)	11, 837, 057	86, 979, 224	98, 816, 281	ı I		1202.00

Health Financial Systems	FAYETTE COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1346	Peri od: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prepared: 11/29/2023 3:06 pm

INPATIENT ROUTINE SERVICE COST CENTERS 11.00					10 00/30/2023	11/29/2023 3: 0	
INPATIENT ROUTINE SERVICE COST CENTERS 11.00 11.00 12.00 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.10 14.00 14.00 14.10 14.00 14.00 14.10 14.00 14.00 14.10 14.00 14.				Title XIX	Hospi tal		
INPATIENT ROUTINE SERVICE COST CENTERS 30,00 30,00 310,00		Cost Center Description	PPS Inpatient				
IMPATIENT ROUTINE SERVICE COST CENTERS 30.00 31.00 031000 03100 03100 03100 03100 03100 03100 03100 03		•					
30.00 03000 03000 ADULTS & PEDIATRICS 31.00 44.00 04400 SkILLED NURSING FACILITY 44.00 04000 SkILLED NURSING FACILITY 44.00 04000 05000 09264TING ROOM 0.000000 53.00 05500 08264TING ROOM 0.000000 53.00 05500 08264TING ROOM 0.000000 54.00 05500 08264TING ROOM 0.000000 55.00 05500 08264TING ROOM 0.000000 05500 08264TING ROOM 0.000000 05500 08264TING ROOM 0.000000 05500 08264TING ROOM 0.000000 0.000000 0.00000 0.00000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000			11. 00				
31.00		INPATIENT ROUTINE SERVICE COST CENTERS					
44. 00	30.00	03000 ADULTS & PEDIATRICS					30.00
ANCILLARY SERVICE COST CENTERS S0. 00	31.00	03100 INTENSIVE CARE UNIT					31.00
50.00 05000 05000 05000 05000 05000 05000 0500 050000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 05000000 0500000 05000000 05000000 05000000 05000000 05000000 05000000 05000000 05000000 05000000 05000000 05000000 050000000 050000000 050000000 050000000 0500000000	44.00	04400 SKILLED NURSING FACILITY					44.00
53.00 05300 AISTHESI OLOGY 0.000000 53.00 53.00 54.00 54.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 60.00 60.0000 60.00000 60.000000 60.000000 60.00000 60.00000 60.000000 60.000000 60.000000 60.000000 60.000000 60.000000 60.000000 60.000000 60.000000 60.000000 60.0000000 60.0000000 60.0000000 60.0000000 60.00000000 60.00000000 60.000000000 60.000000000 60.0000000000		ANCILLARY SERVICE COST CENTERS	<u>'</u>				
53.00 05300 ANESTHESI OLOGY 0.000000 53.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	50.00	05000 OPERATI NG ROOM	0. 000000				50.00
55.00 05500 ABJOLOCOY-THERAPEUTIC 0.000000 06000 ABORATORY 0.0000000 06000 ABORATORY 0.0000000 06000 ABORATORY 0.0000000 06500 RESPIRATORY THERAPY 0.0000000 06500 RESPIRATORY THERAPY 0.0000000 065.00 066.00 06600 PHYSICAL THERAPY 0.0000000 067.00 0	53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
60. 00 06000 LABORATORY 0.000000 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 66. 00 66. 00 66. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 69. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY 0.000000 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 66. 00 66. 00 66. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 67. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 69. 00	55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
66. 00 06600 PHYSI CAL THERAPY 0. 000000 67. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 68. 00 68. 00 06800 SPEECH PATHOLOGY 0. 000000 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 73. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0. 000000 73. 00 00 0770 07700 ALLOGENEI C HSCT ACQUI SITION 0. 000000 73. 00 00 0770 07700 ALLOGENEI C HSCT ACQUI SITION 0. 000000 74. 00 00 0770 07700 ALLOGENEI C HSCT ACQUI SITION 0. 000000 74. 00 00 08800 RURAL HEALTH CLINI C 0. 000000 88. 01 09. 01 09002 WOUND CARE 0. 000000 90. 00 09. 01 09002 WOUND CARE 0. 000000 90. 00 09. 01 09002 WOUND CARE 0. 000000 90. 00 09. 02 09003 PAIN MANAGEMENT 0. 000000 90. 03 09. 04 09004 FAMI LY MEDI CINE 0. 000000 90. 03 09. 04 09005 SURGERY 0. 000000 90. 05 09. 05 09005 SURGERY 0. 000000 90. 05 09. 06 09005 SURGERY 0. 000000 90. 05 09. 07 09007 PULIMONOLOGY 0. 000000 90. 05 09. 08 04950 FAMI LY MEDI CINE NP 0. 000000 90. 05 09. 09 09009 09000 09000 09000 09000 09000 09. 01 09009 ENDOCRI NOLOGY 0. 000000 90. 05 09. 01 09009 ENDOCRI NOLOGY 0. 000000 90. 05 09. 02 09009 09000 09000 09000 09000 09000 070 00 09000 09000 09000 09000 09000 09000 071 00 09000 09000 09000 09000 09000 09000 071 00 09000 09000 09000 09000 09000 09000 09000 071 00 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 090000 09000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 0900000 0900000 0900000 0900000 0900000 0900000 0900000 09000000 0900000 0900000 09000000 09000000 090000	60.00		0. 000000				60.00
67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 68. 00 06800 SPECH PATHOLOGY 0. 000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 000000 73. 00 07300 DRUIS CHARGED TO PATIENT 0. 000000 73. 00 07300 DRUIS CHARGED TO PATIENT 0. 000000 73. 00 07300 DRUIS CHARGED TO PATIENT 0. 000000 73. 00 07700 ALLOGENEIC HSCT ACQUISITION 0. 000000 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000	65.00	06500 RESPIRATORY THERAPY	0. 000000				65.00
67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 68. 00 06800 SPECH PATHOLOGY 0. 000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 000000 73. 00 07300 DRUIS CHARGED TO PATIENT 0. 000000 73. 00 07300 DRUIS CHARGED TO PATIENT 0. 000000 73. 00 07300 DRUIS CHARGED TO PATIENT 0. 000000 73. 00 07700 ALLOGENEIC HSCT ACQUISITION 0. 000000 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000	66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
68. 00 0.6800 SPEECH PATHOLOGY 0.000000 71.00	67.00		1				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 000000 73. 00 7300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 07700 DRUGS CHARGED TO PATIENTS 0. 000000 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0. 000000 0770 ALLOGENEIC HSCT ACQUISITION 0. 000000 088. 00 08800 RURAL HEALTH CLINIC 0. 000000 88. 01 08801 RURAL HEALTH CLINIC 1 0. 000000 90. 00 09000 CLINIC 0. 000000 90. 01 09002 WOUND CARE 0. 000000 90. 01 09002 WOUND CARE 0. 000000 90. 01 09002 WOUND CARE 0. 000000 90. 02 09003 PAIN MANAGEMENT 0. 000000 90. 03 09001 NEUROLOGY 0. 000000 90. 03 09001 NEUROLOGY 0. 000000 90. 05 09005 SURGERY 0. 000000 90. 05 09006 RHEUMATOLOGY 0. 000000 90. 05 09006 RHEUMATOLOGY 0. 000000 90. 05 09007 PULNONOLOGY 0. 000000 90. 05 09007 PULNONOLOGY 0. 000000 90. 05 09007 PULNONOLOGY 0. 000000 90. 05 09007 09007 09007 000000 90. 00 09007 09007 000000 90. 00 09007 0000000 90. 00 09007 000000 90. 00 09009 ENDECKINOLOGY 0. 000000 90. 00 000000 90. 00 000000 90. 00 000000 90. 00 000000 90. 00 000000 90. 00 000000 90. 00 0000000 90. 00 0000000 90. 00 0000000 90. 00 00000000 90. 00 00000000 90. 00 0000000000	68.00		0. 000000				68.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 000000 73. 00 7300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 07700 DRUGS CHARGED TO PATIENTS 0. 000000 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0. 000000 0770 ALLOGENEIC HSCT ACQUISITION 0. 000000 088. 00 08800 RURAL HEALTH CLINIC 0. 000000 88. 01 08801 RURAL HEALTH CLINIC 1 0. 000000 90. 00 09000 CLINIC 0. 000000 90. 01 09002 WOUND CARE 0. 000000 90. 01 09002 WOUND CARE 0. 000000 90. 01 09002 WOUND CARE 0. 000000 90. 02 09003 PAIN MANAGEMENT 0. 000000 90. 03 09001 NEUROLOGY 0. 000000 90. 03 09001 NEUROLOGY 0. 000000 90. 05 09005 SURGERY 0. 000000 90. 05 09006 RHEUMATOLOGY 0. 000000 90. 05 09006 RHEUMATOLOGY 0. 000000 90. 05 09007 PULNONOLOGY 0. 000000 90. 05 09007 PULNONOLOGY 0. 000000 90. 05 09007 PULNONOLOGY 0. 000000 90. 05 09007 09007 09007 000000 90. 00 09007 09007 000000 90. 00 09007 0000000 90. 00 09007 000000 90. 00 09009 ENDECKINOLOGY 0. 000000 90. 00 000000 90. 00 000000 90. 00 000000 90. 00 000000 90. 00 000000 90. 00 000000 90. 00 0000000 90. 00 0000000 90. 00 0000000 90. 00 00000000 90. 00 00000000 90. 00 0000000000	71. 00						
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000							
77. 00 07700 ALLOGENEIC HSCT ACOUISITION 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000							
SERVICE COST CENTERS							77. 00
88. 00							
88. 01 08801 RURAL HEALTH CLINIC II 0.000000 90.00 0.00000	88.00		0. 000000				88.00
90. 01							
90. 01	90.00	09000 CLI NI C	0. 000000				90.00
90. 03							
90. 03	90. 02						90.02
90. 04 09004 FAMILLY MEDICINE 0. 000000 90. 04 90. 05 09005 SURGERY 0. 000000 90. 05 90. 06 09005 SURGERY 0. 000000 90. 05 90. 06 09006 RHEUMATOLOGY 0. 000000 90. 07 90. 07 90. 07 PULMONOLOGY 0. 000000 90. 07 90. 08 04950 FAMILLY MEDICINE - NP 0. 000000 90. 08 90. 09 09008 OP NURSING SERVICE 0. 000000 90. 09 90. 10 09009 ENDDOCRINOLOGY 0. 000000 90. 10 91. 00 09100 EMERGENCY 0. 000000 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 000000 07HER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0. 000000 95. 00 102. 00 10200 OPI OI D TREATMENT PROGRAM 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (see instructions) Less Observation Beds 200. 00 201. 00 Less Observation Beds 201. 00							
90. 05 09005 SURGERY 0. 000000 90. 05 90. 06 09006 RHEUMATOLOGY 0. 000000 90. 06 90. 07 09007 PULMONOLOGY 0. 000000 90. 07 90. 08 0490 FAMILY MEDICINE - NP 0. 000000 90. 08 90. 09 09008 OP NURSING SERVICE 0. 000000 90. 09 90. 10 09009 ENDDOCRINOLOGY 0. 000000 90. 10 91. 00 09100 EMERGENCY 0. 000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 000000 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 102. 00 10200 OPI 0I D TREATMENT PROGRAM 5PECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00							
90. 06 09006 RHEUMATOLOGY 0. 000000 90. 07 09007 PULMONOLOGY 0. 000000 90. 07 90. 08 04950 FAMI LY MEDI CI NE - NP 0. 000000 90. 08 90. 09 09008 OP NURSI NG SERVI CE 0. 000000 90. 10 09009 ENDDOCRI NOLOGY 0. 000000 91. 00 09100 EMERGENCY 0. 000000 91. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0. 000000 92. 00 071HER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0. 000000 95. 00 0102. 00 10200 OPI OI D TREATMENT PROGRAM 5PECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 2							
90. 07 90. 08 04950 FAMILY MEDICINE - NP 0. 000000 90. 09 90. 09 90. 09 90. 09 90. 09 90. 10 90. 09 90. 10 90. 09 90. 10 90. 09 90. 10 90. 09 90. 10 90. 09 90. 10 90. 09 90. 10 90. 09 90. 10 90. 09 90. 10 90. 09 90. 10 90. 09 90. 10 90. 09 90. 10 90. 09 90. 10 90. 09 90. 10 90. 09 90. 10 90. 09 90. 10 90. 09 90. 10 90. 00 90. 00 90. 10 90. 00 90. 00 90. 00 90. 10 90. 00 90. 00 90. 10 90. 00 90. 00 90. 00 90. 10 90. 00 90. 00 90. 00 90. 00 90. 10 90. 00			1				
90. 08							
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90. 10	90.09	09008 OP NURSING SERVICE	1				90.09
91. 00	90. 10		1				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 0000000 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0. 000000 95. 00 102. 00 10200 OPI 0I D TREATMENT PROGRAM 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00							91.00
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00							
95. 00 09500 AMBULANCE SERVICES 0.000000 95. 00 102.00 10200 OPI 0I D TREATMENT PROGRAM 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00		` '					
102.00 10200 OPI 0I D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	95.00		0. 000000				95.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00							
113. 00 11300 11300 11300 11300 200. 00 201. 00 Less Observation Beds 113. 00 200. 00 201. 00							
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	113.00					1	13.00
201.00 Less Observation Beds 201.00							
		,					

Health Financial Systems	FAYETTE COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od:	Worksheet D	
				From 07/01/2022 To 06/30/2023		norod.
				10 06/30/2023	Date/Time Pre 11/29/2023 3:	pareu: O6 nm
		Title	xVIII	Hospi tal	Cost	оо рііі
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)		,	
	col. 26)	,	,			
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	381, 210	4, 106, 817	0. 09282	4 105, 939	9, 834	50.00
53. 00 05300 ANESTHESI OLOGY	0	0	0. 00000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	206, 890	25, 249, 525	0. 00819	4 342, 435	2, 806	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	19, 944	1, 358, 253	0. 01468	4 11, 343	167	55.00
60. 00 06000 LABORATORY	145, 788	22, 388, 410	0. 00651	2 532, 717	3, 469	60.00
65. 00 06500 RESPIRATORY THERAPY	27, 258	2, 027, 645	0. 01344	3 305, 878	4, 112	65.00
66. 00 06600 PHYSI CAL THERAPY	23, 711	3, 530, 505	0. 00671	6 86, 760	583	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 509	664, 153	0.00377	8 21, 749	82	67.00
68. 00 06800 SPEECH PATHOLOGY	1, 593	210, 124	0. 00758	1 12, 949	98	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 453	2, 758, 246	0. 00197	7 341, 341	675	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	6, 970	1, 178, 230	0. 00591	6 354, 714	2, 098	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	54, 330	9, 299, 369	0. 00584	2 653, 521	3, 818	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	19, 619	1, 956, 361	0. 01002	8 0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	3, 308	554, 921	0. 00596	1 0	0	88. 01
90. 00 09000 CLI NI C	15, 274	1, 799, 235	0. 00848	9 0	0	90.00
90. 01 09002 WOUND CARE	12, 928	610, 741	0. 02116	8 0	0	90. 01
90. 02 09003 PAIN MANAGEMENT	2, 937	46, 258	0.06349	2 0	0	90. 02
90. 03 09001 NEUROLOGY	0	0	0. 00000	0	0	90. 03
90.04 09004 FAMILY MEDICINE	10, 875	141, 243	0. 07699	5 0	0	90.04
90. 05 09005 SURGERY	11, 939	582, 323	0. 02050	2 0	0	90.05
90. 06 09006 RHEUMATOLOGY	1, 955	74, 679	0. 02617	9 0	0	90.06
00 07 00007 DULMONOLOOV	1 004	407 400	0 04070		_	1 00 07

1, 884

2,074

4, 786

81, 042

19, 424

1, 064, 600

899

137, 492

205, 961 977, 009

110, 471 12, 849, 548

1, 228, 532

94, 046, 051

0. 013703

0.010070

0. 004899 0. 008138

0.006307

0.015811

55, 081

2, 824, 427

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28, 613 200. 00

871

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90.09

90.10

91.00

92.00 95.00

90. 07 09007 PULMONOLOGY

91.00

90. 08 04950 FAMILY MEDICINE - NP

92. 00 09200| 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
95. 00 09500| AMBULANCE SERVICES

Total (lines 50 through 199)

90. 09 | 09008 | OP NURSI NG SERVI CE | 90. 10 | 09009 | ENDDOCRI NOLOGY

09100 EMERGENCY

Heal th Fin	ancial Systems	FAYETTE COUNTY	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTI ONN THROUGH CO		ANCILLARY SERVICE OTHER PASS	Provi der CCN: 14-1346	From 07/01/2022	Worksheet D Part IV Date/Time Prepared:

				To 06/30/2023	Date/Time Pre 11/29/2023 3:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	1	0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0	1	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	1	0	0	55.00
60. 00 06000 LABORATORY	0	0	1	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	1	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	1	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	1	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	1	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	73.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	_		ı			
88. 00 08800 RURAL HEALTH CLINIC	0	0		0	0	88.00
88. 01 08801 RURAL HEALTH CLINIC II	0	0		0	0	88. 01
90. 00 09000 CLI NI C	0	0		0	0	90.00
90. 01 09002 WOUND CARE	0	0		0	0	90. 01
90. 02 09003 PAI N MANAGEMENT	0	0		0	0	90.02
90. 03 09001 NEUROLOGY	0	0		0	0	90.03
90. 04 09004 FAMI LY MEDI CI NE	0	0		0	0	90.04
90. 05 09005 SURGERY	0	0		0	0	90.05
90. 06 09006 RHEUMATOLOGY 90. 07 09007 PULMONOLOGY	0	0		0	0	90.06
	0	0		0	0	90. 07 90. 08
	0	0	1	0	0	
90. 09 09008 OP NURSI NG SERVI CE	0	0		0	0	90.09
90. 10 09009 ENDDOCRI NOLOGY	0	0		0	0	90. 10
91. 00 09100 EMERGENCY	0	0		0	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0			υĮ	0	92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES			1			05 00
						95.00
200.00 Total (lines 50 through 199)	0	0	1	0	l 0	200. 00

Heal th Financial	Systems		FAYETTE COUNT	TY HOSP	I TAL		In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT OF THROUGH COSTS	I NPATI ENT/OUTPATI ENT	ANCILLARY SE	ERVICE OTHER PAS	SS Pro	ovider C		Period: From 07/01/2022 To 06/30/2023		
					Title	: XVIII	Hospi tal	Cost	
Cost	Center Description		All Other	Total	Cost	Total	Total Charges	Ratio of Cost	
			Medi cal	(sum o	f cols.	Outpati ent	(from Wkst.	to Charges	
			Educati on	1, 2,	3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
			Cost	4	4)	col s. 2, 3,	col. 8)	col. 7)	
						1 4 1		/	

			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			· · · · · ·	and 4)		(see	
						instructions)	
		4. 00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0	4, 106, 817	0.000000	50.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	25, 249, 525	0. 000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	1, 358, 253	0. 000000	55.00
60.00	06000 LABORATORY	0	0	0	22, 388, 410		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	2, 027, 645		65.00
66.00	06600 PHYSI CAL THERAPY	0	0	0	3, 530, 505	0. 000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	664, 153		67.00
	06800 SPEECH PATHOLOGY	0	0	0	210, 124		1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2, 758, 246		1
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	1, 178, 230		1
	07300 DRUGS CHARGED TO PATIENTS	0	0	0			1
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	
	OUTPATIENT SERVICE COST CENTERS				<u> </u>		1
88.00	08800 RURAL HEALTH CLINIC	0	0	0	1, 956, 361	0.000000	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	0	554, 921	0.000000	88. 01
90.00	09000 CLI NI C	0	0	0	1, 799, 235	0.000000	90.00
90. 01	09002 WOUND CARE	0	0	0	610, 741	0.000000	90. 01
90. 02	09003 PAIN MANAGEMENT	0	0	0	46, 258	0.000000	90.02
90. 03	09001 NEUROLOGY	0	0	0	0	0.000000	90. 03
90. 04	09004 FAMILY MEDICINE	0	0	0	141, 243	0.000000	90.04
90. 05	09005 SURGERY	0	0	0	582, 323	0.000000	90.05
90.06	09006 RHEUMATOLOGY	0	0	0	74, 679	0.000000	90.06
90. 07	09007 PULMONOLOGY	0	0	0	137, 492	0.000000	90. 07
90. 08	04950 FAMILY MEDICINE - NP	0	0	0	205, 961	0.000000	90.08
90.09	09008 OP NURSING SERVICE	0	0	0	977, 009	0.000000	90.09
90. 10	09009 ENDDOCRI NOLOGY	0	0	0	110, 471	0.000000	90. 10
91.00	09100 EMERGENCY	0	0	0	12, 849, 548		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	l .				1
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0	0	94, 046, 051		200.00

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	FAYETTE COUNTY	Provi der C	∩N. 14 1244	Peri od:	u of Form CMS-2 Worksheet D	2002 10
	TOWNENT OF INPATTENT/OUTPATTENT ANCILLARY SEI CH COSTS	RVICE UTHER PASS	Provider C	UN: 14-1346	From 07/01/2022 To 06/30/2023	Part IV Date/Time Pre 11/29/2023 3:	pared: 06 pm
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	·	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	h Charges	Pass-Through	
		(col. 6 ÷		Costs (col.	8	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	105, 939		0 0	0	50.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	342, 435		0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	11, 343		0 0	0	55.00
60.00	06000 LABORATORY	0. 000000	532, 717		0 0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	305, 878		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	86, 760		0 0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	21, 749		0 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	12, 949		0 0	0	68.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	341, 341		0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000	354, 714		0 0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	653, 521		0 0	0	73.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88. 01
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01	09002 WOUND CARE	0. 000000	0		0 0	0	90. 01
90. 02	09003 PAIN MANAGEMENT	0. 000000	0		0 0	0	90.02
90. 03	09001 NEUROLOGY	0. 000000	0		0 0	0	90.03
90. 04	09004 FAMILY MEDICINE	0. 000000	0		0 0	0	90.04
90. 05	09005 SURGERY	0. 000000	0		0 0	0	90.05
90. 06	09006 RHEUMATOLOGY	0. 000000	0		0 0	0	90.06
90. 07	09007 PULMONOLOGY	0. 000000	0		0 0	0	90.07
90. 08	04950 FAMILY MEDICINE - NP	0. 000000	0		0 0	0	90.08
90. 09	09008 OP NURSING SERVICE	0. 000000	0		0 0	0	90.09
90. 10	09009 ENDDOCRI NOLOGY	0. 000000	0		0 0	0	90. 10
91. 00	09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	55, 081	I	0	0	92.00

2, 824, 427

0

0

0 200.00

0 92.00 95.00

92. 00 | 09200 | 08SERVATION BEDS (NON-DISTINCT PART) |
OTHER REIMBURSABLE COST CENTERS |
95. 00 | 09500 | AMBULANCE SERVICES |
200. 00 | Total (lines 50 through 199)

APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od: From 07/01/2022	Worksheet D Part V	
					To 06/30/2023	Date/Time Pre	pared:
			Title	xVIII	Hospi tal	11/29/2023 3: Cost	06 pm
			11.01	Charges	поорт сал	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	•	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not	, ,	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.	·	Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0. 597294	l .			0	
53.00	05300 ANESTHESI OLOGY	0. 000000		1	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 096456	0	7, 597, 30	3 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 365089	0	469, 17	6 0	0	55.00
60.00	06000 LABORATORY	0. 205748	0	6, 326, 39	1 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 317549	0	398, 74	5 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 376046	0	924, 48	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 294997	0	141, 45	2 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 794912	0	48, 77	3 0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 137049	0	349, 60	1 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 426632	0	9, 22	6 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 363908	0	3, 814, 50	8 0	0	73.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	l l						88. 00
88. 01	08801 RURAL HEALTH CLINIC II						88. 01
90. 00	09000 CLI NI C	0. 413038	l .	, , , , , ,		_	90.00
90. 01	09002 WOUND CARE	0. 670772	l .	020,02		0	90. 01
90. 02	09003 PAIN MANAGEMENT	2. 259955	l .	7, 47		0	90. 02
90. 03	09001 NEUROLOGY	0. 000000			0	0	90. 03
90. 04	09004 FAMILY MEDICINE	4. 235339	l .	27, 63		0	90. 04
90. 05	09005 SURGERY	1. 257860	l .	43, 73		0	90. 05
90.06	09006 RHEUMATOLOGY	1. 195021	l .	9, 28		0	90.06
90. 07	09007 PULMONOLOGY	0. 608232	l .	23, 39		0	90. 07
90.08	04950 FAMILY MEDICINE - NP	0. 337190	l .	22, 28		0	90. 08
90. 09	09008 OP NURSING SERVICE	0. 235402	l .	381, 93	9 0	0	90. 09
90. 10	09009 ENDDOCRI NOLOGY	0. 565361				0	90. 10
91.00	09100 EMERGENCY	0. 398327					91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 739874	0	458, 71	7 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS		1	1	_1		
	09500 AMBULANCE SERVICES	0. 000000		1	0		95.00
200.00		1	0	26, 458, 34		0	200.00
201.00	9				0		201. 00
202.00	Only Charges Net Charges (line 200 - line 201)			26, 458, 34	1 0	_	202. 00
202.00	p The charges (Title 200 - Title 201)	Į.	1	20, 400, 34	'	ı	1202.00

Health Financial Systems	FAYETTE COUNTY	u of Form CMS-2552-10		
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 14-1346	Peri od: From 07/01/2022	

					From 07/01/2022 To 06/30/2023	Part V Date/Time Pre 11/29/2023 3:	
			Title	XVIII	Hospi tal	Cost	00 рііі
		Cos	sts				
	Cost Center Description	Cost	Cost				
	·	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS	,					
50.00	05000 OPERATING ROOM	454, 167	0				50.00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	732, 805	0				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	171, 291	0				55.00
60.00	06000 LABORATORY	1, 301, 642	0				60.00
65.00	06500 RESPI RATORY THERAPY	126, 621	0				65.00
66.00	06600 PHYSI CAL THERAPY	347, 647	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	41, 728	0				67.00
68.00	06800 SPEECH PATHOLOGY	38, 770	0				68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	47, 912	0				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	3, 936	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 388, 130	0				73.00
	07700 ALLOGENEIC HSCT ACQUISITION	0	0				77.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC						88. 00
88. 01	08801 RURAL HEALTH CLINIC II						88. 01
90.00	09000 CLI NI C	733, 487	0				90.00
90. 01	09002 WOUND CARE	220, 368	0				90. 01
90. 02	09003 PAIN MANAGEMENT	16, 898	0				90. 02
90. 03	09001 NEUROLOGY	0	0				90. 03
90.04	09004 FAMILY MEDICINE	117, 044	0				90. 04
	09005 SURGERY	55, 018	0				90.05
90.06	09006 RHEUMATOLOGY	11, 097	0				90.06
90. 07	09007 PULMONOLOGY	14, 227	0				90. 07
90. 08	04950 FAMILY MEDICINE - NP	7, 514	0				90. 08
90. 09	09008 OP NURSING SERVICE	89, 909	0				90.09
90. 10	09009 ENDDOCRI NOLOGY	7, 694	0				90. 10
91. 00	09100 EMERGENCY	1, 006, 123					91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	339, 393					92.00
0	OTHER REIMBURSABLE COST CENTERS	22.7070					1
95. 00	09500 AMBULANCE SERVICES	0					95.00
200.00		7, 273, 421	0				200.00
201.00		0					201.00
2000	Only Charges						
202. 00		7, 273, 421	0				202. 00

APPORTI ONMENT	OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	1	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Pre 11/29/2023 3:	epared:
			Ti tl	Title XLX Hospital		Cost	
				Charges		Costs	
Co	ost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	·	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not	, ,	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3.00	4. 00	5. 00	
ANCI LLAF	RY SERVICE COST CENTERS			•			
50. 00 05000 OP	PERATING ROOM	0. 597294	0	134, 00	4 0	0	50.00
53. 00 05300 AN	NESTHESI OLOGY	0. 000000	1	1	0	0	53.00
	ADI OLOGY-DI AGNOSTI C	0. 096456	0	734, 23	1 0	0	
1 1	ADI OLOGY-THERAPEUTI C	0. 365089	0	30, 45		0	1
	ABORATORY	0. 205748		419, 08		0	1
	ESPI RATORY THERAPY	0. 317549	١	49, 170	1	0	
1 1	HYSI CAL THERAPY	0. 376046		32, 57		0	00.00
	CCUPATI ONAL THERAPY	0. 376046		12, 60		0	
1 1					1	•	07.00
1 1	PEECH PATHOLOGY	0. 794912	0	7, 17		0	
1 1	EDICAL SUPPLIES CHARGED TO PATIENTS	0. 137049	ł		0	0	
	MPL. DEV. CHARGED TO PATIENT	0. 426632	l e	1	0	0	
	RUGS CHARGED TO PATIENTS	0. 363908	ł	62, 70	1	0	
	LOGENEIC HSCT ACQUISITION	0. 000000	0	(0	0	77. 00
	ENT SERVICE COST CENTERS	T		T			ļ
	JRAL HEALTH CLINIC						88. 00
	JRAL HEALTH CLINIC II						88. 01
90. 00 09000 CL		0. 413038	0	(이	0	
	DUND CARE	0. 670772	0		0	0	
	AIN MANAGEMENT	2. 259955	0)	0	0	
90. 03 09001 NE	EUROLOGY	0. 000000	0)	0	0	90.03
	AMILY MEDICINE	4. 235339	0)	0	0	
90. 05 09005 SU	JRGERY	1. 257860	0)	0	0	90.05
90.06 09006 RH	HEUMATOLOGY	1. 195021	0		0	0	90.06
90. 07 09007 PU	JLMONOLOGY	0. 608232	0)	0	0	90.07
90. 08 04950 FA	AMILY MEDICINE - NP	0. 337190	0)	ol ol	0	90.08
90. 09 09008 OP	NURSING SERVICE	0. 235402	0		ol ol	0	90.09
	NDDOCRI NOLOGY	0. 565361	1	,	0	0	90. 10
91. 00 09100 EM		0. 398327	l o	581, 12	0	0	
	BSERVATION BEDS (NON-DISTINCT PART)	0. 739874	0	1		0	
	EI MBURSABLE COST CENTERS		_		- 1		1
	MBULANCE SERVICES	0. 000000	0				95.00
	ubtotal (see instructions)	3. 223000	١	2, 098, 390	ol ol	Λ	200.00
	ess PBP Clinic Lab. Services-Program		Ĭ	2,070,070		O	201.00
	nly Charges			1	1		201.00
	et Charges (line 200 - line 201)		0	2, 098, 390	ol	0	202.00
202.00	onar gos (Trile 200 Trile 201)	l .	١ ٠	1 2,070,370	- ₁	U	1202.00

Health Financial Systems	FAYETTE COUNTY	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1346	Peri od: From 07/01/2022	Worksheet D Part V Date/Time Prepared:

					To 06/30/2023		epared:
			Ti tl	e XIX	Hospi tal	Cost	00 p
		Cos					
	Cost Center Description	Cost	Cost	1			
	·	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	80, 040	0	1			50.00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	70, 821	0				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	11, 120	0				55.00
60.00	06000 LABORATORY	86, 225	0				60.00
65.00	06500 RESPI RATORY THERAPY	15, 614	0				65.00
66.00	06600 PHYSI CAL THERAPY	12, 248	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	3, 720	0				67.00
68.00	06800 SPEECH PATHOLOGY	5, 704	0				68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	1			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	22, 817	0	1			73.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	1			77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC						88. 00
88. 01	08801 RURAL HEALTH CLINIC II						88. 01
90.00	09000 CLI NI C	0	0				90.00
90. 01	09002 WOUND CARE	0	0				90. 01
90. 02	09003 PAIN MANAGEMENT	0	0				90. 02
90. 03	09001 NEUROLOGY	0	0				90. 03
90.04	09004 FAMILY MEDICINE	0	0				90. 04
90.05	09005 SURGERY	0	0				90. 05
90.06	09006 RHEUMATOLOGY	0	0				90.06
90. 07	09007 PULMONOLOGY	0	0				90. 07
90. 08	04950 FAMILY MEDICINE - NP	0	0				90. 08
90. 09	09008 OP NURSING SERVICE	0	0				90. 09
90. 10	09009 ENDDOCRI NOLOGY	0	0				90. 10
91.00	09100 EMERGENCY	231, 477	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	26, 093	0				92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0					95.00
200.00	Subtotal (see instructions)	565, 879	0	1			200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	565, 879	0	1			202.00

Health Financial Systems	FAYETTE COUNTY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1346	Peri od: From 07/01/2022	Worksheet D-1	
				Date/Time Pre 11/29/2023 3:	
		Title XVIII	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private roo	om days and swing-bed day	ys, excluding newborn)		2, 920	1.00

	Cost Center Description	COST	
	DADT I ALL DDOVIDED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2, 920	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1, 770	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	1, 243	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	363	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	457	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	107	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	165	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	165	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	100	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	691	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	363	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	457	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	188. 44	19. 00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	188. 44	20. 00
21. 00	Total general inpatient routine service cost (see instructions)	4, 529, 369	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
20.00	x line 18)	o .	20.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	31, 093	24.00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8)	31, 093	25. 00
	x line 20)	2., 2.2	
26.00	Total swing-bed cost (see instructions)	1, 476, 506	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	3, 052, 863	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)	0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	3, 052, 863	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY DDOCDAM INDATIENT OPERATING COST DEEDE DASS THROUGH COST AD HISTMENTS		
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	1, 724. 78	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	1, 191, 823	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	1 101 922	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 191, 823	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provi der (Peri od:	u of Form CMS-2 Worksheet D-1	
				From 07/01/2022 To 06/30/2023	Date/Time Pre	
		Ti +I	e XVIII	Hospi tal	11/29/2023 3: Cost	06 pm
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	1. 00	2.00	3.00	4. 00	5. 00	42.00
Intensive Care Type Inpatient Hospital Unit:	6					42.00
43. 00 I NTENSI VE CARE UNI T	0	1	0.0	0	0	
44. 00 CORONARY CARE UNIT 45. 00 BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
<u> </u>					1. 00	
48.00 Program inpatient ancillary service cost (W 48.01 Program inpatient cellular therapy acquisit			t III lino 10	column 1)	833, 206 0	1
49.00 Total Program inpatient costs (sum of lines				corumii 1)	2, 025, 029	
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program in	patient routine	services (fro	om Wkst. D, sur	n of Parts I and	0	50.00
51.00 Pass through costs applicable to Program in	patient ancilla	ry services (1	from Wkst. D, s	sum of Parts II	0	51.00
and IV) 52.00 Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00 Total Program inpatient operating cost excl		elated, non-ph	nysician anesth	netist, and	0	
medical education costs (line 49 minus line	52)	·				
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	
55.01 Permanent adjustment amount per discharge	ugo only)				0.00	
55.02 Adjustment amount per discharge (contractor 56.00 Target amount (line 54 x sum of lines 55, 5	J ,)			0.00	
57.00 Difference between adjusted inpatient opera		•	(line 56 minus	line 53)	0	
58.00 Bonus payment (see instructions)	!: FF &				0 0. 00	58. 00 59. 00
59.00 Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket						
60.00 Expected costs (lesser of line 53 ÷ line 54	00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the					
market basket) 61.00 Continuous improvement bonus payment (ifli 55.01, or line 59, or line 60, enter the le	sser of 50% of	the amount by	which operation	ng costs (line	0	61.00
53) are less than expected costs (lines 54 enter zero. (see instructions)	x 60), or 1 % o	f the target a	amount (line 50	b), otherwise		
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive pay	ment (see instr	uctions)			0	63. 00
PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine co	sts through Dec	ember 31 of th	ne cost reporti	na period (See	626, 095	64. 00
instructions) (title XVIII only)	· ·		·			
65.00 Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	sts after Decem	ber 31 of the	cost reporting	g period (See	788, 224	65.00
66.00 Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line	65)(title XVII	I only); for	1, 414, 319	66.00
CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routi	no costo throug	h Docombor 21	of the cost re	porting poriod	0	67.00
(line 12 x line 19)	ne costs throug	ii becember 31	of the cost is	sporting period		07.00
68.00 Title V or XIX swing-bed NF inpatient routi	ne costs after	December 31 of	f the cost repo	orting period	0	68. 00
(line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 + lir	ne 68)		0	69.00
PART III - SKILLED NURSING FACILITY, OTHER I	NURSING FACILIT	Y, AND ICF/II	ONLY			1
70.00 Skilled nursing facility/other nursing faci 71.00 Adjusted general inpatient routine service)		70.00
72.00 Program routine service cost (line 9 x line		11110 70 : 11110	, 2)			72.00
73.00 Medically necessary private room cost appli						73.00
74.00 Total Program general inpatient routine ser 75.00 Capital-related cost allocated to inpatient	•		•	Part II column		74. 00 75. 00
26, line 45)	Toutine service	C COSTS (110m	WOT RESTREET B,	art II, coramir		70.00
76.00 Per diem capital related costs (line 75 ÷ l						76. 00 77. 00
77.00 Program capital-related costs (line 9 x lin 78.00 Inpatient routine service cost (line 74 min						78.00
79.00 Aggregate charges to beneficiaries for exce		provi der recor	rds)			79.00
80.00 Total Program routine service costs for com		cost limitatio	on (line 78 min	nus line 79)		80.00
81.00 Inpatient routine service cost per diem lim		1)				81.00
82.00 Inpatient routine service cost limitation (83.00 Reasonable inpatient routine service costs						82. 00 83. 00
84.00 Program inpatient ancillary services (see i		,				84.00
85.00 Utilization review - physician compensation						85.00
86.00 Total Program inpatient operating costs (su PART IV - COMPUTATION OF OBSERVATION BED PA:						86.00
87.00 Total observation bed days (see instruction					527	87. 00
87.00 Total observation bed days (see Histruction	- /					

Health Financial Systems	Health Financial Systems FAYETTE COUNTY HOSPITAL In Lieu			u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
			From 07/01/2022 To 06/30/2023			
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			908, 959	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	96, 788	4, 529, 369	0. 02136	908, 959	19, 424	90.00
91.00 Nursing Program cost	0	4, 529, 369	0.00000	908, 959	0	91.00
92.00 Allied health cost	o	4, 529, 369	0.00000	908, 959	0	92.00
93.00 All other Medical Education	o	4, 529, 369	0. 00000	908, 959	0	93.00

Health Financial Systems FAYETTE COUNTY HOSPITAL			u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-1346	Peri od: From 07/01/2022	Worksheet D-1
	Component CCN: 14-5499		
	Title XVIII	Skilled Nursing	PPS
		Facility	
Cost Center Description			

10, 200 Injentient days (including private room days, excluding swing-bed and newborn days). If you have room days (celluding swing-bed and observation bed days). If you have only private room days. 60 on to complete this line. 4.00 Seel-private room days (excluding swing-bed and observation bed days). If you have only private room days. 5.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line). 7.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line). 7.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost total swing-bed SMF type inpatient days. (Including private room days) after December 31 of the cost total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost total swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and nesborn days) (see instructions). 10.00 Sking-bed SMF type inpatient days applicable to the Program (excluding private room days) after December 31 of the cost reporting period (if callendar year, interval to the cost reporting period (if callendar year, interval to the program (excluding private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line). 10.00 Sking-bed SMF type inpatient days applicable to title SWI only (including private room days). 10.01 Sking-bed SWF type inpatient days applicable to title SWI only (including private room days). 10.02 Sking-bed SWF type inpatient days applicable to title SWI only (including private room days). 10.03 Sking-bed SWF type inpatient days applicable to services after December 31 of the cost reporting period (including private room days). 10.04 Sking-bed SWF type inpatient days applicable to service service becember 31 of the cost reporting period (including private			Facility		
NAME		Cost Center Description		1 00	
1.0.00 Inpatient days (including private room days, excluding peaborn) 1.0.795 1.00 1.00 Inpatient days (including private room days, excluding saing-bed and newborn days) 1.0.795 2.00 1.00 Inpatient days (including private room days, excluding saing-bed and newborn days) 1.00 2.00 1.00 Inpatient days (including private room days, excluding avaing bed and observation bed days) 1.00 2.00 1.00 2		PART I - ALL PROVIDER COMPONENTS		1.00	
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1.00 10 10 10 10 10 10 1	5.00		days) through December 31 of the cost	0	5.00
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Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	7. 00		days) through December 31 of the cost	0	7.00
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85.00 Utilization review - physician compensation (see instructions) 0 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) 0 86.00	83. 00	Reasonable inpatient routine service costs (see instructio					83.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 0 86.00				ons)				
PARI IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		Total Program inpatient operating costs (sum	of lines 83 t	hrough 85)				1
	87 ∩∩						0	87. 00

Health Financial Systems	FAYETTE COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
		Component (CCN: 14-5499	From 07/01/2022 To 06/30/2023		pared: 06 pm_
		Title	: XVIII	Skilled Nursing	PPS	
			_	Facility		
Cost Center Description						
					1.00	
88.00 Adjusted general inpatient routine cost per	diem (line 27	÷ line 2)			0.00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	0	0	0.00000	00 0	0	90.00
91.00 Nursing Program cost	0	0	0. 00000	00	0	91.00
92.00 Allied health cost	0	0	0. 00000	00	l o	92.00
93.00 All other Medical Education	0	0	0. 00000	00	0	93.00

Health Financial Systems	FAYETTE COUNTY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 14-1346	Peri od: From 07/01/2022	Worksheet D-1		
			To 06/30/2023	Date/Time Pre 11/29/2023 3:		
		Title XIX	Hospi tal	Cost		
Cost Center Description						
				1. 00		
PART I - ALL PROVIDER COMPONENTS						
I NPATI ENT DAYS					1	
1.00 Inpatient days (including private room	Inpatient days (including private room days and swing-bed days, excluding newborn)					
2.00 Inpatient days (including private room	Inpatient days (including private room days, excluding swing-bed and newborn days)					
3.00 Private room days (excluding swing-bed	d and observation bed da	ys). If you have only p	rivate room days,	0	3. 00	

PART 1 - ALL PRINTERS CORPORATIS PARTITUR DWS		Cost Center Description	1. 00	
Impatient days (Including private room days and swing-bed days, excluding newborn)		PART I - ALL PROVIDER COMPONENTS		
1,770 2,00 Private room days (calcularing private room days) = 1,770 2,00 2,00 Private room days (calcularing swing-bed and observation bed days). If you have only private room days 1,243 4,00 5,00 1,245 4,00 1,245 4,00 1,2		I NPATI ENT DAYS		
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 3.0 do not complete this line. 1.243 4.00			, , , ,	
do not complete this line. 1. 243 d. 0.0 Semi-private room days (excluding swing-bed and observation bed days) 1. 1243 d. 0.0 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1. 1243 d. 0.0 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1. 1243 d. 0.0 Total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1. 1243 d. 0.0 Total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period case in the swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period case in the swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and neaborn days) (see instructions) 1. 1250 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and neaborn days) (see instructions) 1. 1260 Swing-bed SMF type inpatient days applicable to title SWIII only (including private room days) after through December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) applicable to services after December 31 of the cost reporting period (including private room days) applicable to services strough December 31 of the cost reporting pe				
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7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 31,093 25.00 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 32. 00 Average private room per diem charge (line 29 ± line 3) 33. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 052, 863 37.00 27 minus line 36) 28. 00 Adjusted general inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 15, 523 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			-	
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Average per diem private room cost differential (line 35) 30.00 Average per diem private room cost differential (line 35) 30.00 Average per diem private room cost differential (line 35) 30.00 Average per diem private room cost differential (line 35) 30.00 Average per diem private room cost differential (line 35) 30.00 Average per diem private room cost differential (line 35) 30.00 Average per diem private room cost differential (line 35) 30.00 Average per diem private room cost differential (line 35) 30.00 Average per diem private room cost differential (line 35) 30.00 Average per diem private room cost differential (line 35) 30.00 Average per diem private room cost differential (line 35) 30.00 Average per diem private room cost differential (line 35) 30.00 Average per diem private room cost differential (line 35) 30.00 Average per diem private room cost differential (line 35) 30.00 Average per diem private room cost differential (line 35) 30.00 Average per diem priva	24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	31, 093	24.00
x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 General inpatient routine service cost net of swing-bed and observation bed charges) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 31.00 Average perivate room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 0.00 and		7 x line 19)		
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30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 052, 863) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0.00 000000 31.00 0 0.00 000000 32.00 0 0.00 00000 32.00 0 0.00 000000 000000 000000 00000000				
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33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 052, 863) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 15, 523 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 33.00 0.00 34.00 37.00 35.00 37.00 27 minus line 36) PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 1, 724.78 38.00 15, 523 39.00				
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 052, 863) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0. 00	32.00
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3,052,863) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 35.00 0.36.00 37.00 1.724.78 38.00 15,523 9.00			0. 00	
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3,052,863) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 38.00 39.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 0.52, 863) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,724.78 38.00 Program general inpatient routine service cost (line 9 x line 38) 15,523 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,724.78 38.00 Program general inpatient routine service cost (line 9 x line 38) 15,523 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,724.78 38.00 Program general inpatient routine service cost (line 9 x line 38) 15,523 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37.00	· · · · · · · · · · · · · · · · · · ·	3, 052, 863	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,724.78 38.00 15,523 39.00 40.00				
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,724.78 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,724.78 38.00 15,523 39.00 40.00				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 15,523 39.00 40.00	38. 00		1, 724, 78	38, 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			· ·	
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 15,523 41.00	40.00			
	41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	15, 523	41.00

	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	165	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	165	8.00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	9	9.00
	newborn days) (see instructions)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17.00
	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18.00
	reporting period		
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	188. 44	19.00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	188. 44	20.00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	4, 529, 369	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 4	0	23.00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	31, 093	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	31, 093	25.00
	x line 20)		
	Total swing-bed cost (see instructions)	1, 476, 506	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3, 052, 863	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
	Pri vate room charges (excluding swing-bed charges)	0	29. 00
	Semi-private room charges (excluding swing-bed charges)	0	30.00
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.00
	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
	Average per diem private room cost differential (line 34 x line 31)	0. 00	35.00
	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00		3, 052, 863	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 724. 78	
	Program general inpatient routine service cost (line 9 x line 38)	15, 523	39. 00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	15, 523	41. 00

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	FAYETTE COUNT		CN: 14-1346	Period:	u of Form CMS-2 Worksheet D-1	
					From 07/01/2022 To 06/30/2023		
						11/29/2023 3:	
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	<u>'</u>	I npati ent	Inpatient	Diem (col. 1		(col. 3 x	
		1.00	2. 00	÷ col . 2) 3.00	4.00	col. 4) 5.00	
2. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.
	Intensive Care Type Inpatient Hospital Units						
3.00	INTENSIVE CARE UNIT	0	(0.0	00 0	0	43.
4. 00 5. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						45.
5. 00	SURGI CAL INTENSI VE CARE UNI T						46.
7. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1. 00	
3. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			2, 252	48.
3. 01	Program inpatient cellular therapy acquisiti	on cost (Worksh	neet D-6, Part	III, line 10	, column 1)	0	
9. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	01)(see instru	ctions)		17, 775	49.
0. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D. su	m of Parts I and	0	50.
	[111)		·				
1. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	0	51.
. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				o	52
3. 00	Total Program inpatient operating cost exclu	ding capital re	elated, non-ph	ysician anest	hetist, and	0	1
	medical education costs (line 49 minus line	52)	·	-			
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
. 00	Target amount per discharge					0. 00	
. 01	Permanent adjustment amount per discharge					0. 00	
. 02	Adjustment amount per discharge (contractor					0. 00	
00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			line 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	ing cost and te	irget amount (Title 50 illitius	111le 55)	0	
. 00							
00	updated and compounded by the market basket)						
0. 00	D Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						
1.00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of t	the amount by	which operatio	ng costs (line	0	61.
2. 00	Relief payment (see instructions)					0	62
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ambar 31 of th	e cost report	ing period (See	0	64
. 00	instructions)(title XVIII only)	its through bece	elliber 31 of th	e cost reporti	riig perrou (see	١	04
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporting	g period (See	o	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costs (lino	44 plue line	4E) (+i +l o V)/I	II only). for	0	66
. 00	CAH, see instructions	ne costs (Title	04 prus rine	os)(title xvi)	ii oniy), ioi	ا	00
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	o	67
	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	o costs often [Nocombor 21 of	the cost ron	orting poriod	ا	40
. 00	(line 13 x line 20)	e costs ditel L	recember 31 OI	the cost repo	or tring period	0	68
. 00	Total title V or XIX swing-bed NF inpatient					0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service c				′		71
00	Program routine service cost (line 9 x line	71)		ŕ			72
. 00	Medically necessary private room cost applic		•				73
. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II, column		75
	26, line 45)		`		·		
00	Per diem capital related costs (line 75 ÷ li						76
00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77
	Aggregate charges to beneficiaries for exces		rovi der recor	ds)			79
00	Total Program routine service costs for comp	arison to the o			nus line 79)		80
00	Inpatient routine service cost per diem limi						81
. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82
()()	Program inpatient ancillary services (see in		,				84
	Utilization review - physician compensation						85
. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS	of lines 83 th					86

Health Financial Systems	Health Financial Systems FAYETTE COUNTY HOSPITAL In Lieu			u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2022 To 06/30/2023		
		Ti tl e	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			908, 959	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	96, 788	4, 529, 369	0. 02136	908, 959	19, 424	90.00
91.00 Nursing Program cost	0	4, 529, 369	0.00000	0 908, 959	0	91.00
92.00 Allied health cost	0	4, 529, 369	0.00000	0 908, 959	0	92.00
93.00 All other Medical Education	o	4, 529, 369	0. 00000	0 908, 959	0	93. 00

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-1346	Peri od:	Worksheet D-3	3
				From 07/01/2022 To 06/30/2023	Date/Time Pre 11/29/2023 3:	
		Ti tl e	XVIII	Hospi tal	Cost	оо р.
	Cost Center Description	<u> </u>	Ratio of Cos	t Inpatient	I npati ent	
	·		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		•			
0.00				1, 068, 020		30.
1.00	03100 INTENSIVE CARE UNIT			0		31.
	ANCILLARY SERVICE COST CENTERS					
0.00	05000 OPERATING ROOM		0. 59729	94 105, 939	63, 277	50.
3. 00	05300 ANESTHESI OLOGY		0. 00000		0	
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 09645		33, 030	
5. 00	05500 RADI OLOGY-THERAPEUTI C		0. 36508		4, 141	1
0. 00	06000 LABORATORY		0. 20574		109, 605	
5. 00	06500 RESPI RATORY THERAPY		0. 31754		97, 131	1
6. 00	06600 PHYSI CAL THERAPY		0. 37604		32, 626	
7. 00	06700 OCCUPATI ONAL THERAPY		0. 29499		6, 416	
8.00			0. 7949		10, 293	1
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 13704		46, 780	
2.00			0. 42663		151, 332	
3. 00 7. 00	07300 DRUGS CHARGED TO PATIENTS		0. 36390		237, 822	
7.00	07700 ALLOGENEI C HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS		0. 00000	00 0	0	77.
8. 00			0.00000	20	0	88.
8. 01	08801 RURAL HEALTH CLINIC II		0. 00000		0	
0.00			0. 41303		0	
0. 01	09002 WOUND CARE		0. 6707		0	
0. 02			2. 25995		0	
0. 03	09001 NEUROLOGY		0.00000		0	
0. 04	09004 FAMILY MEDICINE		4. 23533		0	90.
0. 05	09005 SURGERY		1. 25786		0	
0. 06	09006 RHEUMATOLOGY		1. 19502		0	
0. 07	09007 PULMONOLOGY		0. 60823		0	
0. 08	04950 FAMILY MEDICINE - NP		0. 33719		0	90.
0. 09	09008 OP NURSING SERVICE		0. 23540		0	90.
0. 10	09009 ENDDOCRI NOLOGY		0. 56536	51 0	0	90.
1. 00	09100 EMERGENCY		0. 39832		0	91.
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 73987	74 55, 081	40, 753	92.
	OTHER REIMBURSABLE COST CENTERS					
5. 00						95.
00.00				2, 824, 427	833, 206	1
01. 00		rges (line 61)		0		201.
02.00	Net charges (line 200 minus line 201)		I	2, 824, 427		202.

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-1346	Peri od:	Worksheet D-3	3
		Component	CCN: 14-Z346	From 07/01/2022 To 06/30/2023	Date/Time Pre 11/29/2023 3:	
		Title	e XVIII	Swing Beds - SNF	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00	03000 ADULTS & PEDIATRICS					30.
1. 00	03100 NTENSI VE CARE UNI T					31.
	ANCILLARY SERVICE COST CENTERS					
0. 00	05000 OPERATING ROOM		0. 5972	·	5, 063	
3. 00	05300 ANESTHESI OLOGY		0.0000		0	
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 0964	·	12, 102	
5. 00	05500 RADI OLOGY-THERAPEUTI C		0. 3650		2, 553	1
0.00	06000 LABORATORY		0. 2057	·	55, 917	
5. 00	06500 RESPI RATORY THERAPY		0. 3175		54, 423	
5. 00	06600 PHYSI CAL THERAPY		0. 3760		92, 617	
7.00	06700 OCCUPATI ONAL THERAPY		0. 2949		46, 279	
3.00	06800 SPEECH PATHOLOGY		0. 7949	·	17, 190	
1.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 1370	·	18, 919	
2.00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS		0. 4266		142.011	1
3. 00 7. 00	07700 ALLOGENEIC HSCT ACQUISITION		0. 3639	·	163, 911	73. 77.
7.00	OUTPATIENT SERVICE COST CENTERS		0.0000	00 0	0	//.
8. 00	08800 RURAL HEALTH CLINIC		0.0000	00	0	88.
3. 01	08801 RURAL HEALTH CLINIC II		0.0000		ő	
0.00	09000 CLI NI C		0. 4130		Ö	
0. 01	09002 WOUND CARE		0. 6707		0	
0. 02	09003 PAIN MANAGEMENT		2. 2599		0	
0. 03	09001 NEUROLOGY		0.0000	00 0	0	90.
0. 04	09004 FAMILY MEDICINE		4. 2353		0	90.
0. 05	09005 SURGERY		1. 2578	60 0	0	90.
0. 06	09006 RHEUMATOLOGY		1. 1950	21 0	0	90.
0. 07	09007 PULMONOLOGY		0. 6082	32 0	0	90.
0. 08	04950 FAMILY MEDICINE - NP		0. 3371	90 0	0	90.
0. 09	09008 OP NURSING SERVICE		0. 2354	02 0	0	90.
). 10	09009 ENDDOCRI NOLOGY		0. 5653	61 0	0	90.
1.00	09100 EMERGENCY		0. 3983		0	
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7398	74 29, 659	21, 944	92.
	OTHER REIMBURSABLE COST CENTERS					
5. 00						95.
00.00				1, 627, 013	490, 918	
01.00		arges (line 61)		0		201.
02.00	Net charges (line 200 minus line 201)			1, 627, 013		202

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CCN: 14-1346	Peri od: From 07/01/2		
				To 06/30/2	D23 Date/Time P 11/29/2023	
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos	t Inpatient		
			To Charges	Program	Program Cost	S
				Charges	(col. 1 x	
					col . 2)	
	INDATIENT DOUTINE CEDVICE COST CENTERS		1.00	2. 00	3. 00	_
0.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		1	12,	241	30.
	03100 INTENSIVE CARE UNIT			12,	0	30.
1.00	ANCI LLARY SERVI CE COST CENTERS				<u> </u>	→ ^{31.}
0.00	05000 OPERATING ROOM		0. 5972	24	O	0 50.
3. 00	05300 ANESTHESI OLOGY		0.0000		0	0 53.
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0.0964		0	0 54.
5. 00	05500 RADI OLOGY-THERAPEUTI C		0. 3650		0	0 55.
0.00	06000 LABORATORY		0. 2057		303 1, 40	
5. 00	06500 RESPIRATORY THERAPY		0. 2037	·	0	0 65.
5. 00	06600 PHYSI CAL THERAPY		0. 3760		o	0 66.
7. 00	06700 OCCUPATI ONAL THERAPY		0. 2949		0	0 67.
3. 00	06800 SPEECH PATHOLOGY		0. 7949		0	0 68.
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1370		0	0 71.
	07200 IMPL. DEV. CHARGED TO PATIENT		0. 42663		0	0 72.
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 36390		-	52 73.
	07700 ALLOGENEIC HSCT ACQUISITION		0. 00000		0	0 77.
7.00	OUTPATIENT SERVICE COST CENTERS		0.0000	30	0	٠, ب
3. 00	08800 RURAL HEALTH CLINIC		0. 8995	43	0	0 88.
3. 01	08801 RURAL HEALTH CLINIC II		0. 6226		o	0 88.
0.00	09000 CLINIC		0. 4130		o o	0 90.
0. 01	09002 WOUND CARE		0. 6707		o	0 90.
). 02	09003 PAIN MANAGEMENT		2. 2599!		ol	0 90.
0. 03	09001 NEUROLOGY		0. 00000		ol	0 90.
0. 04	09004 FAMILY MEDICINE		4. 2353		ol	0 90.
0. 05	09005 SURGERY		1. 2578		ol	0 90.
0. 06	09006 RHEUMATOLOGY		1. 1950		o	0 90.
0. 07	09007 PULMONOLOGY		0. 60823		o	0 90.
0. 08	04950 FAMILY MEDICINE - NP		0. 33719		o	0 90.
0. 09	09008 OP NURSING SERVICE		0. 23540		o	0 90.
). 10	09009 ENDDOCRI NOLOGY		0. 5653		ol	0 90.
1. 00	09100 EMERGENCY		0. 3983		o	0 91.
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7398		o	0 92.
	OTHER REIMBURSABLE COST CENTERS			- <u> </u>		
5. 00	09500 AMBULANCE SERVI CES					95.
00.00				9.	143 2, 2!	52 200.
01. 00		ges (line 61)			o	201.
02.00		5	1	0	143	202.

Health Financial Systems	FAYETTE COUNTY HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CC	Peri od: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/29/2023 3:06 pm

-	Title XVIII	Hospi tal	11/29/2023 3: Cost	ов рш
	PART B - MEDICAL AND OTHER HEALTH SERVICES		1. 00	
1. 00	Medical and other services (see instructions)		7, 273, 421	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS or REH payments		0	3. 00
4.00	Outlier payment (see instructions)		0	4.00
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions)		0.000	4. 01 5. 00
6. 00	Line 2 times line 5		0.000	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7. 00
8. 00	Transitional corridor payment (see instructions)		0	8.00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions		0	9. 00 10. 00
11. 00			7, 273, 421	
	COMPUTATION OF LESSER OF COST OR CHARGES		.,=:=,	
	Reasonabl e charges			
12.00			0	12. 00 13. 00
13. 00 14. 00			0	14.00
11.00	Customary charges			11.00
15.00		a charge basis	0	15. 00
16. 00		on a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)		0. 000000	17. 00
18. 00			0.000000	18.00
19. 00	,	ine 11) (see	Ō	19. 00
	instructions)			
20. 00		ine 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)		7, 346, 155	21. 00
22. 00			0	22.00
23. 00	· · · · · · · · · · · · · · · · · · ·		0	23. 00
24. 00			0	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coincurance amounts (for CAN, see instructions)		20 040	25. 00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	ructions)	38, 968 4, 081, 210	
27. 00	· · · · · · · · · · · · · · · · · · ·		3, 225, 977	1
	instructions)			
28. 00			0	28.00
28. 50 29. 00			o	28. 50 29. 00
30.00			3, 225, 977	
31.00	Primary payer payments		339	31.00
32. 00			3, 225, 638	32.00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34. 00			169, 652	
35.00			110, 274	35.00
	Allowable bad debts for dual eligible beneficiaries (see instructions)		57, 079	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R		3, 335, 912 0	
39. 00				39.00
39. 50	· · · · · · · · · · · · · · · · · · ·			39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)		0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration	. 12	0	39. 97
39. 98 39. 99		Ctions)	0	39. 98 39. 99
40. 00			3, 335, 912	
40. 01			66, 718	
40. 02			0	
40. 03			4 200 146	40. 03
41. 00 41. 01	1 ' 3		4, 208, 146	41. 00 41. 01
42. 00			0	
42.01	Tentative settlement-PARHM (for contractor use only)			42. 01
43.00			-938, 952	1
43. 01	Balance due provider/program-PARHM (see instructions)	abantan 1		43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	спартег Г,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR			
	Original outlier amount (see instructions)		0	
91.00	· · · · · · · · · · · · · · · · · · ·		0 00	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)		0.00	92. 00 93. 00
	Total (sum of lines 91 and 93)			94.00

Health Financial Systems	FAYETTE COUNTY I	HOSPI TAL	In Lieu	of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT				Worksheet E	
			From 07/01/2022	Part B	
			To 06/30/2023		
				11/29/2023 3:	06 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

| Peri od: | Worksheet E-1 | From 07/01/2022 | Part | To 06/30/2023 | Date/Time Prepared:

				0 06/30/2023	11/29/2023 3:0	
		Title	xVIII	Hospi tal	Cost	00 p
	·		nt Part A		t B	
			A	/ - - /	A	
		mm/dd/yyyy	Amount 2.00	mm/dd/yyyy 3.00	Amount	
1. 00	Total interim payments paid to provider	1.00	1, 380, 515		4. 00 4, 208, 146	1. 00
2. 00	Interim payments payable on individual bills, either		1, 360, 515		4, 208, 146	2.00
2.00	submitted or to be submitted to the contractor for				o o	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		Ι (0	3. 01
3. 02	ADJUSTIMENTS TO PROVIDER				0	3. 01
3. 03					0	3. 03
3. 04			1		0	3. 04
3. 05					0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		()	0	3. 50
3. 51			(0	3.51
3. 52			C		0	3. 52
3. 53					0	3. 53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 54 3. 99
3. 99	3. 50-3. 98)			,	U	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 380, 515		4, 208, 146	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as		',,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1, 200, 110	
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER				0	5. 01
5. 02	TENTATIVE TO TROVIDER					5. 02
5. 03					Ö	5. 03
	Provider to Program	<u>'</u>				
5.50	TENTATI VE TO PROGRAM		C)	0	5. 50
5. 51			c		0	5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
4 00	5.50-5.98)		•			4 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		479, 288	3	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		1,7,200		938, 952	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 859, 803	3	3, 269, 194	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	To the second se	(0	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Provider CCN: 14-1346 | Period: | Worksheet E-1 | Part | | Part |

	Component	0014: 11 2010 1	0 00/00/2020	11/29/2023 3:	06 pm
			wing Beds - SNF		
	I npati en	t Part A	Par	t B	
	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	1.00	2.00	3. 00	4. 00	
1.00 Total interim payments paid to provider		1, 287, 965		0	1.00
2.00 Interim payments payable on individual bills, either		0	1	0	2.00
submitted or to be submitted to the contractor for					
services rendered in the cost reporting period. If none,					
write "NONE" or enter a zero					
3.00 List separately each retroactive lump sum adjustment					3.00
amount based on subsequent revision of the interim rate					
for the cost reporting period. Also show date of each					
payment. If none, write "NONE" or enter a zero. (1)					
Program to Provider					
3.01 ADJUSTMENTS TO PROVIDER		0		0	
3. 02		0		0	
3. 03		0		0	
3. 04		0		0	
3. 05		0		0	3.05
Provider to Program			1		
3.50 ADJUSTMENTS TO PROGRAM		0		0	
3. 51		0		0	
3. 52		0		0	
3. 53		0		0	
3.54		0		0	
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3. 99
4.00 Total interim payments (sum of lines 1, 2, and 3.99)		1, 287, 965		0	4.00
(transfer to Wkst. E or Wkst. E-3, line and column as		1, 207, 703		0	4.00
appropri ate)					
TO BE COMPLETED BY CONTRACTOR	L	l	I	l .	1
5.00 List separately each tentative settlement payment after					5.00
desk review. Also show date of each payment. If none,					0.00
write "NONE" or enter a zero. (1)					
Program to Provider			•		1
5. 01 TENTATI VE TO PROVI DER		0		0	5.01
5. 02		0	1	0	5. 02
5. 03		0	1	0	5.03
Provider to Program					
5.50 TENTATIVE TO PROGRAM		0		0	5. 50
5. 51		0		0	5. 51
5. 52		0		0	
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
5. 50-5. 98)					
6.00 Determined net settlement amount (balance due) based on					6.00
the cost report. (1)					
6. 01 SETTLEMENT TO PROVI DER		564, 954		0	
6.02 SETTLEMENT TO PROGRAM		0		0	
7.00 Total Medicare program liability (see instructions)		1, 852, 919		0	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
	,	`			
8.00 Name of Contractor	()	1. 00	2.00	8. 00

Health Financial Systems FAYETTE COUNTY HOSPITAL In Lieu					-2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 14-1346 Period: From 07/01/2022					
		oporod:				
			To 06/30/2023	11/29/2023 3		
	Title XVIII Hospital					
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REP					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALC				1.00	
	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00 Medicare days (see instructions)					2.00	
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					3. 00	
4. 00	Total inpatient days (see instructions)				4. 00	
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line				5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, c				6. 00	
7.00	CAH only - The reasonable cost incurred for the purcha	ase of certified HIT technology	Wkst. S-2, Pt. I		7. 00	
	line 168					
8. 00	Calculation of the HIT incentive payment (see instruct	i ons)			8. 00	
9.00	Sequestration adjustment amount (see instructions)				9. 00	
10.00	Calculation of the HIT incentive payment after sequest	ration (see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
	Initial/interim HIT payment adjustment (see instruction	ons)			30.00	
	Other Adjustment (specify)				31.00	
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)					32.00	

Health Financial Systems	FAYETTE COUNTY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 14-1346	Peri od: From 07/01/2022	Worksheet E-2	
		Component CCN: 14-Z346			
		Title XVIII	Swing Beds - SNF		оо рііі
			Part A	Part B	

		Component CCN. 14-2346	10 00/30/2023	11/29/2023 3:	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
COMPLITA	TION OF NET COST OF COVERED SERVICES		1.00	2. 00	
	ent routine services - swing bed-SNF (see instructions)	<u> </u>	1, 428, 462	0	1.0
	ent routine services - swing bed-NF (see instructions)		1, 120, 102	Ĭ	2.00
3.00 Ancilla	ry services (from Wkst. D-3, col. 3, line 200, for Par	rt A, and sum of Wkst. D,	495, 827	0	3.0
	cols. 6 and 7, line 202, for Part B) (For CAH and swi	ng-bed pass-through, see			
instruc					
,	g and allied health payment-PARHM (see instructions)			0.00	3.0
00 Per die	em cost for interns and residents not in approved teach	irig program (see		0. 00	4.0
00 Program	,		820	0	5.0
1	and residents not in approved teaching program (see i	nstructions)		0	
00 Utiliza	ntion review - physician compensation - SNF optional me	ethod only	0		7.0
1	l (sum of lines 1 through 3 plus lines 6 and 7)		1, 924, 289	0	
1	payer payments (see instructions)		0	0	
1	d (line 8 minus line 9)		1, 924, 289	0	
	bles billed to program patients (exclude amounts appli	cable to physician	O O	0	11.0
1.	sional services) nl (line 10 minus line 11)		1, 924, 289	0	12.0
	rance billed to program patients (from provider records	s) (exclude coinsurance	33, 555	0	
	sician professional services)	-, (-	
1.00 80% of	Part B costs (line 12 x 80%)			0	14.0
	d (see instructions)		1, 890, 734	0	
1	ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
4	ACO demonstration payment adjustment (see instruction	•			16.5
	community hospital demonstration project (§410A Demonst ment (see instructions)	tration) payment	١		16. 5
	ration payment adjustment amount before sequestration		0	0	16. 9
1	ole bad debts (see instructions)		o	0	
	ed reimbursable bad debts (see instructions)		0	0	17.0
3.00 Allowab	ole bad debts for dual eligible beneficiaries (see inst	tructions)	0	0	18.0
1	(see instructions)		1, 890, 734	0	
1 '	ration adjustment (see instructions)		37, 815	0	
	ration payment adjustment amount after sequestration)		0	0	19.0
	ration adjustment-PARHM pass-throughs ration for non-claims based amounts (see instructions)			0	
	n payments	•	1, 287, 965	0	
1	payments-PARHM		1,20,,700	١	20.0
1	ve settlement (for contractor use only)		0	0	
I. 01 Tentati	ve settlement-PARHM (for contractor use only)				21.0
1	e due provider/program (line 19 minus lines 19.01, 19.0	02, 19.25, 20, and 21)	564, 954	0	
1	e due provider/program-PARHM (see instructions)		_	_	22.0
	ed amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	0	0	23.0
	1, §115.2 ommunity Hospital Demonstration Project (§410A Demonst	ration) Adjustment			1
	s the first year of the current 5-year demonstration pe				200. C
	Cures Act? Enter "Y" for yes or "N" for no.	orrod under the 21st			200. 0
	imbursement				
01.00 Medi car	re swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, line			201. C
	le XVIII hospital))				
	re swing-bed SNF inpatient ancillary service costs (fro	om Wkst. D-3, col. 3, line	9		202. C
	tle XVIII swing-bed SNF)) 'sum of lines 201 and 202)				202 0
1	re swing-bed SNF discharges (see instructions)				203. C
	tion of Demonstration Target Amount Limitation (N/A in	n first year of the curren	nt 5-vear demons		204.0
peri od)	tron or bomonotration ranger randant Eran tation (m/r ri		it o your domone		
5. 00 Medi car	re swing-bed SNF target amount				205. 0
	re swing-bed SNF inpatient routine cost cap (line 205 t				206. 0
	ent to Medicare Part A Swing-Bed SNF Inpatient Reimbur				
1 0	reimbursement under the §410A Demonstration (see inst	•			207.0
	e swing-bed SNF inpatient service costs (from Wkst. E-	-2, col. 1, sum of lines 1	1		208. 0
and 3)	nent to Medicare swing-bed SNF PPS payments (see instru	ictions)			209.0
1 -	ed for future use	actions)			210. 0
	sion of PPS versus Cost Reimbursement				1
					1
	djustment to Medicare swing-bed SNF PPS payment (line	209 plus line 210) (see		i i	215. C

Heal th	Financial Systems	FAYETTE COUNTY	HOSPI TAL		In Lieu	u of Form CMS-2552-10
CALCULA	NTION OF REIMBURSEMENT SETTLEMENT		Provi der CO		From 07/01/2022	Worksheet E-3 Part V Date/Time Prepared: 11/29/2023 3:06 pm
			Title	XVIII	Hospi tal	Cost

				11/29/2023 3:	06 pm_
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpati ent servi ces			2, 025, 029	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2.00
3.00	Organ acqui si ti on			0	3.00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4.00	Subtotal (sum of lines 1 through 3.01)			2, 025, 029	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 045, 279	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
7.00	Routine service charges			0	7.00
8. 00	Ancillary service charges			0	8.00
9. 00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	11.00
12. 00	Amounts that would have been realized from patients liable fo			. 0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)	1 3	3		
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	•		0.000000	13.00
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete on	ly if line 14 exceeds li	ne 6) (see	0	15.00
	instructions)		, ,		
16.00	Excess of reasonable cost over customary charges (complete on	ly if line 6 exceeds lir	ie 14) (see	0	16.00
	instructions)		, ,		
17.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	18. 00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2, 045, 279	19.00
20.00	Deductibles (exclude professional component)			152, 912	20.00
21.00	Excess reasonable cost (from line 16)			0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1, 892, 367	22.00
23.00	Coi nsurance			389	23.00
24.00	Subtotal (line 22 minus line 23)			1, 891, 978	24.00
25.00	Allowable bad debts (exclude bad debts for professional servi-	ces) (see instructions)		8, 892	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			5, 780	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		2, 980	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1, 897, 758	28. 00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	29. 50
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			1, 897, 758	30.00
30. 01	Sequestration adjustment (see instructions)			37, 955	
30.02	Demonstration payment adjustment amount after sequestration			0	30. 02
30.03	Sequestration adjustment-PARHM				30. 03
31.00	Interim payments			1, 380, 515	31.00
31. 01	Interim payments-PARHM				31. 01
32.00	Tentative settlement (for contractor use only)			0	32.00
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.0.	2, 31, and 32)		479, 288	33.00
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m	inus lines 30.03, 31.01,	and 32.01)		33. 01
34.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	34.00
	§115. 2				

	Financial Systems FAYETTE COUNTY			u of Form CMS-	
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1346	Peri od: From 07/01/2022	Worksheet E-3	3
		Component CCN: 14-5499	To 06/30/2023	Part VI Date/Time Pre	nared.
		Component Con. 14-3477	10 00/30/2023	11/29/2023 3:	
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER	HER HEALTH SERVICES FOR	TITLE XVIII PART	A PPS SNF	
	SERVI CES				1
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			0	
2.00	Routine service other pass through costs			0	
3.00	Ancillary service other pass through costs			0	1
4. 00	Subtotal (sum of lines 1 through 3) COMPUTATION OF NET COST OF COVERED SERVICES			0	4.00
5. 00	Medical and other services (Do not use this line as vaccine of	costs are included in Li	no 1 of W/S E		5.00
5.00	Part B. This line is now shaded.)	costs are included in it	THE TOT W/3 L,		3.00
6. 00	Deductible			0	6.00
7. 00	Coinsurance			0	
8. 00	Allowable bad debts (see instructions)			0	
9. 00	Reimbursable bad debts for dual eligible beneficiaries (see i	instructions)		0	1
10.00	Adjusted reimbursable bad debts (see instructions)			0	
11. 00				0	
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines	10 and 11)(see instructi	ons)	0	12.00
13.00	Inpatient primary payer payments	, ,	ĺ	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	14.00
14. 50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	14.50
14. 98	Recovery of accelerated depreciation.	•		0	14. 98
14. 99	Demonstration payment adjustment amount before sequestration			0	14. 99
15.00	Subtotal (see instructions			0	15.00
15. 01	Sequestration adjustment (see instructions)			0	15. 01
15. 02	Demonstration payment adjustment amount after sequestration			0	15. 02
15. 75	Sequestration for non-claims based amounts (see instructions))		0	15. 75
16.00	Interim payments			0	16.00
	Tentative settlement (for contractor use only)			0	1
18. 00	Balance due provider/program (line 15 minus lines 15.01, 15.0			0	
19. 00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS 19 Pub. 15	-2, chapter 1,	0	19. 00
	§115. 2				1

Health Financial Systems	FAYETTE COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1346	Peri od: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2023 3:06 pm
	Ti +I o VI V	Hospi tal	Cost

PART VII				06/30/2023	Date/lime Pre 11/29/2023 3:	
PART VII - CALCILATION OF REIMBURSPANT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			Title XIX	Hospi tal		оо рііі
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITIES V OR XIX SERVICES			II EI S XII X			
PART VI - CALCULATION OF REIMBURSCRAIT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES 1.00 Inpati ent hospital /SNF/NI services 1.7,775 1.00 1.7,775 2.00 Medical and other services 5.66,879 2.00 3.00 1.7,755 5.66,879 2.00 3.00 1.7,953 5.71,538 3.00 1.7,953 5.71,538 3.00 1.7,953 5.71,538 3.00 1.7,953 5.71,538 3.00 1.7,953 5.71,538 3.00 1.7,953 5.71,538 3.00 1.7,953 5.71,538 3.00 1.7,953 5.71,538 3.00 1.7,953 5.71,538 3.00 1.7,953 5.71,538 3.00 1.7,953 5.71,538 3.00 1.7,953 5.71,538 3.00 1.7,953 5.71,538 3.00 1.7,953 5.71,538 3.00 1.7,953 5.71,538 3.00 1.7,953 5.71,538 3.00 1.7,953 3.00 1						
COMPUTATION OF NET COST OF COVERED SERVICES 1,00		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEE	RVICES FOR TITLES V OR XI		2.00	
Inpatient hospital/SWF/MF services 17,775 565,879 2.00 3.00 1.00			Wiele Felt III Lee V elt XI	X 02.X 1 020		1
Medical and other services 56,879 2.00	1. 00			17, 775		1.00
3.00 Cogna acquisition (certified transplant programs only) 3.00				,	565, 879	
A.00 Subtotal (sum of Lines 1, 2 and 3) 571,538 4.00 5.00 6.00 0.				0		1
5.00 Inpatient primary payer payments 0 0 0.00				17, 953	571, 538	1
6.00 Outpatient primary payer payments 0 0 6.00		1		0	,	1
Subtotal (line 4 less sum of lines 5 and 6)					0	
Reasonable Charges 12, 961 9.00 Ancillary service charges 9.143 2,098,390 9.00 10.00 Organ acquisition charges, net of revenue 9.143 2,098,390 9.00 10.00 Incentive from target amount computation 9.00 11.00 10.00 Incentive from target amount computation 9.00 11.00 10.0	7.00			17, 953	571, 538	7.00
Routine service charges 12,961 2,098,390 0,00 0 0 0 0 0 0 0 0		COMPUTATION OF LESSER OF COST OR CHARGES		*		
9.00 Ancillary service charges 9,143 2,098,390 9,00 10.00 10.00 Incentive from target amount computation 0 0 0 10.00 11.00		Reasonabl e Charges				
10.00 Organ acquisition charges, net of revenue 10.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 17.01 reasonable charges (sum of lines 8 through 11) 22,104 2,098,390 12.00 12.00 13.00 13.00 14.00 14.00 14.00 14.00 15.00 14.00 15	8.00	Routine service charges		12, 961		8.00
11.00 Incentive from target amount computation 22, 104 2,098, 390 12.00 20	9.00	Ancillary service charges		9, 143	2, 098, 390	9.00
12.00 Total reasonable charges (sum of lines 8 through 11) 22, 104 2,098,390 12.00	10.00	Organ acquisition charges, net of revenue		0		10.00
CUSTOMARY CHARGES	11.00	Incentive from target amount computation		0		
13.00 Amount actually collected from patients liable for payment for services on a charge basis 14.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 0.0000000 0.000000 0.0000000 0.0000000 0.00000000	12.00	Total reasonable charges (sum of lines 8 through 11)		22, 104	2, 098, 390	12.00
basis 14.00 Anounts that would have been realized from patients liable for payment for services on 0 14.00 a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 22.104 2.998.390 16.00 17.00 Excess of customary charges (see instructions) 22.104 2.998.390 16.00 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 4.151 1.526.852 17.00						
14.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 22.104 2.998, 390 16.00 16.00 Total customary charges over reasonable cost (complete only if line 16 exceeds 4.151 1.526, 852 17.00 16.00	13.00		r services on a charge	0	0	13. 00
a charge basis had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 13 to line 14 (not to exceed 1.000000) 15.00 Total customary charges (see instructions) 17.00 Excess of customary charges (see instructions) 18.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 4) (see instructions) 19.00 Interns and Residents (see instructions) 19.00 Interns and Residents (see instructions) 19.00 Cost of physicians' services in a teaching hospital (see instructions) 19.00 Cost of physicians' services (enter the lesser of line 4 or line 16) 17.953 EXCENTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 19.00 Cost of program capital payments 10 Coultier payments 10 Coultier payments 10 Cost of covered ion payments (see instructions) 20.00 Cost of payments 21 Coultier payments 22 Coultier payments 23 Coultier payments 24 Coultier payments 25 Coultier payments 26 Coultier payments 27 Coultier payments 28 Coultier payments 30 Coultier payments 30 Coultier payments 40 Coustomary charges (either pass through costs and one of payments of payments of payments of payments one of payments of payments one o						
15. 00	14. 00			0	0	14.00
16. 00 Total customary charges (see`instructions) 22, 104 2, 098, 390 16. 00 17. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 4, 151 1, 526, 852 17. 00 11 11 11 12 11 12 11 12 13 13	45.00		42 CFR §413.13(e)			45.00
17. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1, 151 1, 526, 852 17. 00						
Iine 4 (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line			161147			
18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 18.00 19.00 19.00 10	17.00		y IT line 16 exceeds	4, 151	1, 526, 852	17.00
16) (see instructions)	10 00		ly if line 4 exceeds line	0	0	10 00
19.00 Interns and Residents (see instructions) 0 0 0 19.00 20.00	18.00		y II ITHE 4 exceeds ITHE	0	U	18.00
20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 20.00	10 00			0	0	10 00
21.00			cuctions)	Ü		
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22. 00 Other than outlier payments 0 0 22. 00 23. 00 Outlier payments 0 0 23. 00 24. 00 Program capital payments 0 24. 00 25. 00 Capital exception payments (see instructions) 0 0 25. 00 26. 00 Routine and Ancillary service other pass through costs 0 0 25. 00 27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 17, 953 571, 538 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 0 0 30. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 17, 953 571, 538 31. 00 32. 00 Deductibles 0 0 0 32. 00 33. 00 Coinsurance 0 0 32. 00				o o	_	
22. 00 Other than outlier payments 0 0 22. 00 23. 00 Outlier payments 0 0 23. 00 24. 00 Program capital payments 0 24. 00 25. 00 Capital exception payments (see instructions) 0 25. 00 26. 00 Routine and Ancillary service other pass through costs 0 0 26. 00 27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 17, 953 571, 538 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 0 0 30. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 17, 953 571, 538 31. 00 32. 00 Deductibles 0 0 32. 00 33. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 17, 953 571, 538 31. 00 35. 00 Utilization review 0 0 0 32. 00 36. 00 Other Abultymental payments </td <td>21.00</td> <td></td> <td></td> <td></td> <td>371, 330</td> <td>21.00</td>	21.00				371, 330	21.00
23.00 Outlier payments 0	22 00		Compreted for 115 provid		0	22 00
24.00 Program capital payments 24.00 25.00 25.00 26.00 2		1 3				
25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 30. 0 Coinsurance 31. 00 Allowable bad debts (see instructions) 32. 00 Utilization review 33. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 35. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Irect graduate medical education payments (from Wkst. E-4) 40. 00 Interim payments 45. 00 47. 50 48. 00 49. 00 41. 00 Interim payments				0	_	
26.00 Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Coinsurance Allowable bad debts (see instructions) Coinsurance Allowable bad debts (see instructions) Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Titles V or XIX (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	25. 00			0		25.00
27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 17,953 571,538 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 0 0 30. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 17,953 571,538 31. 00 32. 00 Deductibles 0 0 0 32. 00 33. 00 Coi nsurance 0 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 17,953 571,538 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 17,953 571,538 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 70 Total amount payable to the provider (sum of lines 38 and 39) 17,953 571,538 40. 00 41. 00 Interim payments				0	0	26.00
29.00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 30.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31.00 Deductibles 30.00 Coinsurance 30.00 Allowable bad debts (see instructions) 31.00 Allowable bad debts (see instructions) 32.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 571,538 29.00 30.00 30.00 30.00 31.00 30.00 3	27.00	, ,		0	0	27.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 17,953 571,538 31.00 32.00 Deductibles 0 0 0 32.00 33.00 Coi nsurance 0 0 0 34.00 34.00 Allowable bad debts (see instructions) 0 0 0 34.00 35.00 Utilization review 0 0 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 17,953 571,538 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 17,953 571,538 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 0 Total amount payable to the provider (sum of lines 38 and 39) 17,953 571,538 40.00 41.00 Interim payments 5,707 527,557 41.00	28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
30.00 Excess of reasonable cost (from line 18)	29.00	Titles V or XIX (sum of lines 21 and 27)		17, 953	571, 538	29. 00
30.00 Excess of reasonable cost (from line 18)		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
32.00 Deductibles 0 0 32.00 33.00 Coinsurance 0 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 17,953 571,538 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 17,953 571,538 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 17,953 571,538 40.00 41.00 Interim payments 5,707 527,557 41.00	30.00			0	0	30.00
33.00 Coinsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 17,953 571,538 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 17,953 571,538 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 17,953 571,538 40.00 41.00 Interim payments 5,707 527,557 41.00	31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	17, 953	571, 538	31.00
34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 17,953 571,538 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 17,953 571,538 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 17,953 571,538 40.00 41.00 Interim payments 5,707 527,557 41.00	32.00	Deducti bl es		0	0	32.00
35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 17,953 571,538 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 17,953 571,538 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 17,953 571,538 40.00 41.00 Interim payments 5,707 527,557 41.00	33.00	Coinsurance		0	0	33.00
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 571,538 36.00 37.00	34.00	Allowable bad debts (see instructions)		0	0	34.00
37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 571,538 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 17,953 571,538 40.00 41.00 Interim payments 5,707 527,557 41.00				0		
38.00 Subtotal (line 36 ± line 37) 17,953 571,538 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 17,953 571,538 40.00 41.00 Interim payments 5,707 527,557 41.00			d 33)	17, 953	571, 538	
39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 17,953 571,538 40.00 41.00 Interim payments 5,707 527,557 41.00				0	0	
40.00 Total amount payable to the provider (sum of lines 38 and 39) 17,953 571,538 40.00 41.00 Interim payments 5,707 527,557 41.00				17, 953	571, 538	
41.00 Interim payments 5,707 527,557 41.00				0		
42 00 IRalance due provider/program (line 40 minus line 41) 12 246 12 246 12 246 12 200 12 20		1				
	42.00	Balance due provider/program (line 40 minus line 41)		12, 246	43, 981	
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00	43.00		nce with CMS Pub 15-2,	0	0	43.00
chapter 1, §115.2		[cnapter 1, 9115.2				l

Health Financial Systems	FAYETTE COUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1346	Peri od: From 07/01/2022	Worksheet E-3	
	Component CCN: 14-5499			
	Title XIX	Skilled Nursing	Cost	
		Facility		
		Inpatient	Outpati ent	

	THE XIX	Facility	0031	
		Inpatient	Outpati ent	
		1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	7.1.7. OE.N.1. OEO		1
1. 00	Inpatient hospital/SNF/NF services	0		1.00
2. 00	Medical and other services		0	
3. 00	Organ acquisition (certified transplant programs only)	0		3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)	0	•	1
5. 00	Inpatient primary payer payments	0	_	5.00
6. 00	Outpatient primary payer payments	0	0	1
7. 00	Subtotal (line 4 less sum of lines 5 and 6)	0	_	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		10	7.00
	Reasonable Charges			1
8. 00		0	ı	8.00
	Routi ne servi ce charges	-		
9.00	Ancillary service charges	0		
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
40.00	CUSTOMARY CHARGES		1 .	40.00
13. 00	Amount actually collected from patients liable for payment for services on a charge	0	0	13. 00
44.00	basis			
14. 00	Amounts that would have been realized from patients liable for payment for services	on 0	0	14.00
	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	l e	1
	Total customary charges (see instructions)	0	0	
17. 00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	0	0	17. 00
	line 4) (see instructions)			
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds li	ne 0	0	18. 00
	16) (see instructions)			
19. 00	Interns and Residents (see instructions)	0		
20. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	_	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS prov			
	Other than outlier payments	0		
	Outlier payments	0	0	
	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	<u> </u>		
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32. 00	Deducti bl es	0		1
	Coinsurance	0	l o	
	Allowable bad debts (see instructions)	0		
	Utilization review	Ö		35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	•	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	Ö		
38. 00	Subtotal (line 36 ± line 37)	0		
39. 00	Direct graduate medical education payments (from Wkst. E-4)	0	_	39.00
	, , , , , , , , , , , , , , , , , , , ,	0	•	
	Total amount payable to the provider (sum of lines 38 and 39)	0	_	
41. 00	1	J	_	
42.00	Balance due provider/program (line 40 minus line 41)	0		
43. 00		0	0	43. 00
	chapter 1, §115.2	1	I	1

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

Provi der CCN: 14-1346

Peri od: Worksheet G From 07/01/2022 To 06/30/2023 Date/Ti me Prepared: 11/29/2023 3:06 pm

37		General Fund	Speci fi c	Endowment	11/29/2023 3: Plant Fund	06 pm
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS			3, 33		
1. 00	Cash on hand in banks	6, 632, 328	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes recei vable	45 400 053	0	0	0	
4. 00 5. 00	Accounts receivable Other receivable	45, 680, 053 35, 658		0	0	
6. 00	Allowances for uncollectible notes and accounts receivable			0	0	
7. 00	Inventory	294, 262	1	Ö	0	
8. 00	Prepai d expenses	123, 871	0	0	0	8. 00
9. 00	Other current assets	0	0	0	0	
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	16, 297, 582	0	0	0	11.00
12. 00	FIXED ASSETS Land	1 0	0	O	0	12.00
13. 00	Land improvements	0		o	0	
14. 00	Accumulated depreciation	0	0	o	0	14.00
15.00	Bui I di ngs	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17. 00	Leasehold improvements	0	0	0	0	17.00
18. 00 19. 00	Accumulated depreciation	0	0	0	0	18.00
20. 00	Fixed equipment Accumulated depreciation	0	0	0	0	19. 00 20. 00
21. 00	Automobiles and trucks	0	0	0	0	21.00
22. 00	Accumulated depreciation	0	Ö	Ö	0	22.00
23. 00	Maj or movable equipment	17, 876, 745	0	0	0	23. 00
24.00	Accumulated depreciation	-6, 383, 898	0	0	0	24.00
25. 00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27. 00 28. 00	HIT designated Assets	2,773,214	1	O O	0	27. 00 28. 00
29. 00	Accumulated depreciation Minor equipment-nondepreciable	-1, 888, 062	0	0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29)	12, 377, 999	- 1	0	0	30.00
	OTHER ASSETS	.=/ ***/ ***	-,	-,		
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	243, 644 243, 644	1	0	0	34. 00 35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	28, 919, 225	0	0	0	
00.00	CURRENT LIABILITIES	20/7/7/220	<u> </u>	<u> </u>		00.00
37.00	Accounts payable	569, 254	0	0	0	37.00
38. 00	Salaries, wages, and fees payable	1, 565, 636	0	0	0	
39.00	Payrol I taxes payable	0	0	0	0	39.00
40.00	Notes and Loans payable (short term) Deferred income	19, 981, 878	0	O O	0	40.00
41. 00 42. 00	Accel erated payments		0	ď	U	41. 00 42. 00
43. 00	Due to other funds	0	0	0	0	
44. 00	Other current liabilities	2, 954	0	o	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	22, 119, 722	0	0	0	45. 00
	LONG TERM LIABILITIES	,				
46. 00	Mortgage payable	0	0	0	0	46.00
47. 00	Notes payable	910, 560		0	0	
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	0	0	0	0	1
50. 00	Total long term liabilities (sum of lines 46 thru 49)	910, 560	- 1	0	0	
51. 00	Total liabilities (sum of lines 45 and 50)	23, 030, 282	I I	Ö	0	
	CAPI TAL ACCOUNTS		-,	-,		
52.00	General fund balance	5, 888, 943				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			٩	0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				Ü	
59. 00	Total fund balances (sum of lines 52 thru 58)	5, 888, 943	0	0	0	
60.00	Total liabilities and fund balances (sum of lines 51 and	28, 919, 225	0	0	0	60.00
	[59]	I	1			I

Peri od: Worksheet G-1 From 07/01/2022

					To 06/30/2023	Date/Time Pre 11/29/2023 3:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00		0.00		5.00	
1 00	F d. b. d	1. 00	2.00	3.00	4.00	5. 00	1 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		6, 282, 130 -393, 187		0		1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)		5, 888, 943		0		3.00
4. 00	Additions (credit adjustments) (specify)		3, 000, 743		0	0	4.00
5. 00	(Specify)	o o			0	0	5.00
6. 00		o			0	0	6.00
7.00		o			0	0	7. 00
8.00		0			0	0	8.00
9.00		0			0	0	9. 00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11. 00	Subtotal (line 3 plus line 10)	_	5, 888, 943		0	_	11.00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13. 00 14. 00		0			0	0	13.00
15. 00					0	0	14. 00 15. 00
16. 00					0	0	16.00
17. 00					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		5, 888, 943		0		19.00
	sheet (line 11 minus line 18)						
		Endowment	PI ant	Fund			
		Fund					
		6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1.00
2. 00	Net income (loss) (from Wkst. G-3, line 29)	_					2. 00
3.00	Total (sum of line 1 and line 2)	0	0		0		3.00
4. 00 5. 00	Additions (credit adjustments) (specify)		0				4. 00 5. 00
6. 00			0				6.00
7. 00			0				7. 00
8. 00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11.00	Subtotal (line 3 plus line 10)	0			0		11. 00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15. 00			0				15.00
16.00			0				16.00
17. 00 18. 00	Total deductions (sum of lines 12-17)		0		0		17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-1346

			To 06.	/30/2023	Date/Time Pre 11/29/2023 3:	
	Cost Center Description	Inpatient	Outp	ati ent	Total	оо р
	·	1.00	2	. 00	3. 00	
	PART I - PATIENT REVENUES					
1. 00	General Inpatient Routine Services Hospital	3, 112, 4	24		3, 112, 484	1. 00
2.00	SUBPROVIDER - IPF	3, 112, 4	54		3, 112, 404	2.00
3. 00	SUBPROVIDER - IRF					3. 00
4.00	SUBPROVI DER					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	1, 958, 2	97		1, 958, 297	7.00
8. 00 9. 00	NURSING FACILITY OTHER LONG TERM CARE					8. 00 9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	5, 070, 7	81		5, 070, 781	10.00
10.00	Intensive Care Type Inpatient Hospital Services	3, 3, 3, 7	<i>3</i> 1		0,070,701	10.00
11.00	INTENSIVE CARE UNIT	60, 2	90		60, 290	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN I NTENSI VE CARE UNI T					13.00
14.00	SURGI CAL INTENSI VE CARE UNIT					14.00
15. 00 16. 00	OTHER SPECIAL CARE (SPECIFY) Total intensive care type inpatient hospital services (sum of	lines 60, 2	20		60, 290	15. 00 16. 00
10.00	11-15)	111163	70		00, 270	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)) 5, 131, 0	71		5, 131, 071	17. 00
18.00	Ancillary services	6, 840, 2	39 70	, 042, 109	76, 882, 348	18.00
19. 00	Outpatient services	2, 2		, 521, 564	15, 523, 793	19. 00
20.00	RURAL HEALTH CLINIC			, 956, 361	1, 956, 361	20.00
20. 01	RURAL HEALTH CLINIC II		0	554, 921	554, 921	20. 01
21. 00 22. 00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY		U	0	0	21. 00 22. 00
23. 00	AMBULANCE SERVICES		0	0	0	23. 00
24. 00	CMHC			ŭ		24. 00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26.00	HOSPI CE					26. 00
27. 00	CLINIC			, 799, 235	1, 799, 235	
27. 01	WOUND CARE		0	729, 029	729, 029	
27. 02 27. 03	PAIN MANAGEMENT NEUROLOGY		0	214, 270	214, 270 0	27. 02 27. 03
27. 03	DR SKOW	41, 3	-	336, 248	377, 562	27. 03
27. 05	DR BLASER	66, 7		, 537, 167	4, 603, 882	
27. 06	DR RONHOLM		0	95, 346	95, 346	
27. 07	DR BARKOVI AK	5	68	195, 544	196, 112	27. 07
27. 08	NP DI EDRE	178, 4		330, 277	508, 746	
27. 09	OBSERVATION			, 248, 656	1, 248, 656	
27. 10 27. 11	AMBULANCE SERVICES PHYSICIAN REVENUE	67, 1	0 1	0 166, 453 ,	0 1, 233, 644	27. 10 27. 11
27. 11	OTHER OUTPATIENT	07,1	0	, 100, 433 0	1, 233, 044	27. 11
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst. 12, 327, 7	-	, 727, 180	111, 054, 976	
	G-3, line 1)					
	PART II - OPERATING EXPENSES			000 157		
	Operating expenses (per Wkst. A, column 3, line 200)		0 39	, 890, 157		29.00
30. 00 31. 00	ADD (SPECIFY)		0			30. 00 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 (SPECIFY)		U			37.00
38. 00 39. 00			0			38. 00 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 42	2)(transfer	39	, 890, 157		43.00
	to Wkst. G-3, line 4)	I				

llaal +b	Financial Systems FAYETTE COUNTY	LIOCDI TAI	In Lin	u of Form CMS-2	DEED 10
	Financial Systems FAYETTE COUNTY IENT OF REVENUES AND EXPENSES	Provider CCN: 14-1346	Peri od:	Worksheet G-3	2552-10
017112.	ELIT OF THE PERSON ELIGIS		From 07/01/2022		
			To 06/30/2023	Date/Time Prep 11/29/2023 3:0	
				11,2,,2020 0.	<u>оо р</u>
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lim			111, 054, 976	1.00
2.00	Less contractual allowances and discounts on patients' accounts	nts		73, 068, 621	2.00
3.00	Net patient revenues (line 1 minus line 2)			37, 986, 355	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		39, 890, 157	4. 00
5. 00	Net income from service to patients (line 3 minus line 4)			-1, 903, 802	5.00
	OTHER I NCOME		-		,
6. 00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8. 00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8.00
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	10. 00 11. 00
11. 00 12. 00	Rebates and refunds of expenses Parking Lot receipts			0	12.00
12.00	Revenue from Laundry and Linen service			0	12.00
14. 00	Revenue from meals sold to employees and quests			111, 899	
15. 00					15. 00
	Revenue from sale of medical and surgical supplies to other	than nationts		0	16.00
17. 00	,	than patrents		0	17. 00
	Revenue from sale of medical records and abstracts				18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)				19. 00
	Revenue from gifts, flowers, coffee shops, and canteen			ő	20.00
21. 00	Rental of vending machines			896	
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	OTHER OPERATING INCOME			1, 099, 861	24.00
	COVI D-19 PHE Funding			297, 865	
	Total other income (sum of lines 6-24)			1, 510, 615	
26.00	Total (line 5 plus line 25)			-393, 187	26.00
	OTHER EXPENSES (SPECIFY)			0	27. 00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			-393, 187	29. 00

llool +b	Financial Customs	FAVETTE COUNT	V HOCDITAL		المالة ما	u of Form CMS	2552 10
	Financial Systems SIS OF HOSPITAL-BASED RHC/FOHC COSTS	FAYETTE COUNT	Provider C	CN: 14 1244	Peri od:	u of Form CMS-: Worksheet M-1	
ANALIS	STS OF HOSFITAL-BASED KIRC/TQTC COSTS		FIOVIDE	CN. 14-1340	From 07/01/2022		
			Component	CCN: 14-8527	To 06/30/2023		
					RHC I	Cost	
		Compensation	Other Costs		1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Tri al Bal ance	
						(col. 3 +	
		1. 00	2.00	2 00	4.00	col . 4) 5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3. 00	4.00	3.00	
1. 00	Physician	206, 052	0	206, 0	52	206, 052	1.00
2. 00	Physician Assistant	178, 958	0			116, 426	
3. 00	Nurse Practitioner	310, 392	0		· ·	310, 392	1
4. 00	Visiting Nurse	310, 372	0		0 0	0	1
5. 00	Other Nurse	194, 339	0		-	194, 339	
6. 00	Clinical Psychologist	171,007	0	171,0	0	0	1
7. 00	Clinical Social Worker	o o	0		0 0	Ö	
8. 00	Laboratory Techni ci an	o o	0		0 0	0	
9. 00	Other Facility Health Care Staff Costs	39, 172	0	39, 1 ⁻	72 0	39, 172	
10.00	Subtotal (sum of lines 1 through 9)	928, 913	0	928, 9		866, 381	10.00
11. 00	Physician Services Under Agreement	0	0	1	0 0	0	
12. 00	Physician Supervision Under Agreement	ol	0	,	0 0	0	1
13.00	Other Costs Under Agreement	o	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	o	0		0 0	0	14.00
15.00	Medical Supplies	0	1, 551	1, 5!	51 0	1, 551	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	o	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19. 00	Other Health Care Costs	0	0)	0	0	19. 00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	1, 551			1, 551	1
22. 00	Total Cost of Health Care Services (sum of	928, 913	1, 551	930, 40	-62, 532	867, 932	22. 00
	lines 10, 14, and 21)						
00.00	COSTS OTHER THAN RHC/FQHC SERVICES					1 0	00.00
23. 00	Pharmacy	0	0	1	0 0	0	
24. 00	Dental	0	0		0 0	-	
25. 00 25. 01	Optometry	0	0			0	
25. 01	Telehealth Chronic Care Management	0	0			0	
26. 00	g .	0	0		0 0	0	
26.00	All other nonreimbursable costs Nonallowable GME costs	٩	Ü		0	0	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	
26.00	through 27)	٩	U		0	U	20.00
	FACILITY OVERHEAD						1
29. 00	Facility Costs	ol	50, 310	50, 3	10 0	50, 310	29. 00
30.00	Administrative Costs	121, 259	132, 950			·	1
31. 00	Total Facility Overhead (sum of lines 29 and		183, 260				1
550	30)	1 .2., 207	.00, 200	551, 6	33, 3, 3	1 2.0,010	1 3 55

184, 811

1, 234, 983

-96, 208

1, 138, 775

32.00

1, 050, 172

32.00 Total facility costs (sum of lines 22, 28 and 31)

Heal th	Financial Systems	FAYETTE COUN	TY HOSPITAL		In Lieu	of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-1346	Peri od:	Worksheet M-1	
			Component	CCN: 14-8527	From 07/01/2022 To 06/30/2023	Date/Time Pre 11/29/2023 3:	pared: 06 pm
					RHC I	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7.00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	C	206, 052				1.00
2.00	Physician Assistant	0	116, 426				2.00

	Financial Systems IS OF HOSPITAL-BASED RHC/FQHC COSTS	FAYETTE COUNT	Provi der C	CN: 14-1346	Peri od:	Worksheet M-1	
			Component	CCN: 14-8528	From 07/01/2022 To 06/30/2023	Date/Time Pre	narodi
			Component	CCN. 14-0320	10 00/30/2023	11/29/2023 3:	
					RHC II	Cost	
		Compensation	Other Costs		1 Reclassi fi cat	Reclassified	
				+ col . 2)	i ons	Tri al Balance	
						(col. 3 + col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	0		0 0	0	
2. 00	Physician Assistant	0	0		0 62, 532	62, 532	1
3.00	Nurse Practitioner	0	0		0	0	
4.00	Visiting Nurse	0 51 030	0	F1 0	0 0	0	
5. 00 6. 00	Other Nurse Clinical Psychologist	51, 938	0	51, 93	0 0	51, 938 0	
7. 00	Clinical Psychologist Clinical Social Worker	0	0		0 0	0	
8. 00	Laboratory Techni ci an	0	0			0	
9. 00	Other Facility Health Care Staff Costs	0	0		0	0	
10.00	Subtotal (sum of lines 1 through 9)	51, 938	0	51, 93	62, 532	114, 470	
11. 00	Physician Services Under Agreement	0	0	.,	0 0	0	
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	12		12 0	12	
16. 00	Transportation (Health Care Staff)	0	0		0	0	
17. 00	Depreciation-Medical Equipment	0	0		0 0	0	
18.00	Professional Liability Insurance	0	0		0	0	
19.00		U	0		0 0	0	19.00 20.00
20.00	Allowable GME Costs Subtotal (sum of lines 15 through 20)	0	12		12 0	12	
22. 00	Total Cost of Health Care Services (sum of	51, 938	12			114, 482	
22.00	lines 10, 14, and 21)	31, 930	12	51, 7	02, 332	114, 402	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23. 00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0	0	
25.00	Optometry	0	0		0	0	
25. 01	Tel eheal th	0	0		0 0	0	
25. 02	9	0	0		0 0	0	
26.00	All other nonreimbursable costs	0	0		0	0	
27. 00	Nonallowable GME costs					0	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		0 0	0	28. 00
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	41, 804	41, 80	04 0	41, 804	29.00
30.00	Administrative Costs	44, 857	28, 652			77, 723	
31.00	Total Facility Overhead (sum of lines 29 and	44, 857	70, 456			119, 527	31.00
	30)	,	-,		.,	., . =-	
32.00	Total facility costs (sum of lines 22, 28	96, 795	70, 468	167, 26	66, 746	234, 009	32.00
	and 31)			I			1

Health Financial Systems	FAYETTE COUN	TY HOSPI TAL		In Lieu	of Form CMS-2	552-10
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS		Provi der C	CN: 14-1346	Peri od: From 07/01/2022	Worksheet M-1	
		Component	CCN: 14-8528		Date/Time Prep 11/29/2023 3:0	pared: 06 pm
				RHC II	Cost	'
	Adjustments	Net Expenses				
		for				
		Allocation				
		(col. 5 +				
		col. 6)				
	6. 00	7. 00				
FACILITY HEALTH CARE STAFF COSTS	<u>.</u>					
1 00 11	_	-				

			for		
			Allocation		
			(col. 5 +		
			col. 6)		
		6. 00	7.00		
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00		
1. 00	Physi ci an	0	0		1.00
2. 00	Physician Assistant	0	62, 532	l .	2.00
3.00	Nurse Practitioner	0	02,002		3.00
4. 00	Visiting Nurse	0	0	l control of the cont	4.00
5. 00	Other Nurse	0	51, 938	l .	5.00
6. 00	Clinical Psychologist	0	31, 730 N		6.00
7. 00	Clinical Social Worker	0	0		7.00
8. 00	Laboratory Techni ci an	0	0		8.00
9. 00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	114, 470		10.00
11. 00	Physician Services Under Agreement	0	114,470		11.00
12. 00	Physician Supervision Under Agreement	0	0		12.00
13. 00	Other Costs Under Agreement	0	0		13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15. 00		0	12	l .	15.00
16.00	Medical Supplies	0	0	l .	16.00
17. 00	Transportation (Health Care Staff)	0	0	l .	17.00
	Depreciation-Medical Equipment	0	0		18.00
18.00	Professional Liability Insurance	0	0		19.00
	Other Health Care Costs	U	U		20.00
20.00	Allowable GME Costs	0	12		21.00
21. 00	Subtotal (sum of lines 15 through 20)	0	12 114, 482	l control of the cont	1
22. 00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	U	114, 482		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23. 00	Pharmacy	0	0		23.00
24. 00	Dental	0	0		24.00
25. 00	Optometry	0	o n		25.00
25. 01	Tel eheal th	0	o n		25. 01
	Chronic Care Management	0	n		25. 02
26. 00	All other nonreimbursable costs	0	0		26.00
27. 00	Nonal Lowable GME costs	O	O		27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		28.00
20.00	through 27)	O	O		20.00
	FACILITY OVERHEAD				
29 00	Facility Costs	0	41, 804		29.00
30.00	Administrative Costs	0	77, 723		30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	119, 527		31.00
31.00	30)	O	117, 327		31.00
32. 00	Total facility costs (sum of lines 22, 28	0	234, 009		32.00
	and 31)	Ŭ	20.,007		
	1 /		1	ı	

	Financial Systems	FAYETTE COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 07/01/2022 To 06/30/2023	Date/Time Pre 11/29/2023 3:	
					RHC I	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	ı	T				
1. 00	Physi ci an	0. 78					1.00
2.00	Physician Assistant	0. 75					2.00
3.00	Nurse Practitioner	2. 57					3. 00
4. 00	Subtotal (sum of lines 1 through 3)	4. 10	•	1	10, 248	· ·	1
5.00	Visiting Nurse	0.00	l e			0	
6.00	Clinical Psychologist	0.00				0	
7.00	Clinical Social Worker	0.00				0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00		l .		0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
8. 00	Total FTEs and Visits (sum of lines 4	4. 10	10, 529			10, 529	8. 00
	through 7)		_			_	
9. 00	Physician Services Under Agreements		0			0	9. 00
						4 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O LIOCDI TAL DACI	ED DUC/FOUR CEI	DVII CEC		1. 00	
	Total costs of health care services (from Wk			RVICES		867, 932	10.00
	Total nonreimbursable costs (from Wkst. M-1,					007, 932	1
12.00	Cost of all services (excluding overhead) (s						
12.00	Ratio of hospital-based RHC/FQHC services (I					867, 932 1, 000000	
14. 00	Total hospital-based RHC/FQHC services (i Total hospital-based RHC/FQHC overhead - (fr			: no 21)		270, 843	
15. 00	Parent provider overhead allocated to facili			The 31)		621, 095	
16. 00	Total overhead (sum of lines 14 and 15)	ty (see mstru	Ctrons)				
	,					891, 938	
	Allowable GME overhead (see instructions)					001.030	
	Enter the amount from line 16	IIC comit cos (1	ino 12 v li	10)		891, 938	1
	Overhead applicable to hospital based RHC/FO					891, 938	
20.00	Total allowable cost of hospital-based RHC/F	unc services (Sum of fines f	u anu 19)	ı	1, 759, 870	₁ 20.00

	Financial Systems	FAYETTE COUN				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der (Peri od:	Worksheet M-2	
			Component		From 07/01/2022 To 06/30/2023	Date/Time Pre 11/29/2023 3:	
					RHC II	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1. 00	Physi ci an	0.00					1.00
2.00	Physician Assistant	0. 35					2.00
3.00	Nurse Practitioner	0.00	l				3. 00
4.00	Subtotal (sum of lines 1 through 3)	0. 35		1	735	1, 208	1
5. 00	Visiting Nurse	0.00	l			0	5. 00
6.00	Clinical Psychologist	0.00	I			0	6. 00
7. 00	Clinical Social Worker	0.00	I			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	I			0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	(0	7. 02
	onl y)						
8. 00	Total FTEs and Visits (sum of lines 4	0. 35	1, 208	3		1, 208	8. 00
	through 7)					_	
9. 00	Physician Services Under Agreements		()		0	9. 00
						4 00	
	DETERMINATION OF ALLOWARIE COCT APPLICABLE T	O HOCDITAL DACI	ED DUC/FOUR CE	DVI CEC		1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVICES		114, 482	10.00
	Total costs of health care services (from Wk Total nonreimbursable costs (from Wkst. M-1,					114, 482	11.00
12.00	Cost of all services (excluding overhead) (s Ratio of hospital-based RHC/FQHC services (I					114, 482	
13.00				: 21)		1.000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			The 31)		119, 527	
15.00	Parent provider overhead allocated to facili	ty (see Instru	Ctions)			111, 500	
16.00	Total overhead (sum of lines 14 and 15)					231, 027	
17.00	Allowable GME overhead (see instructions)					0 231, 027	17. 00 18. 00
	Enter the amount from line 16 Overhead applicable to hospital-based RHC/FQ	NAC convisos (1	ino 12 v lino	10)		231, 027	
	Total allowable cost of hospital-based RHC/FU					231, 027 345, 509	
20.00	Tiotal allowable cost of hospital-based RHC/F	unc services (:	sum OF FIRES I	o allu 19)	ı	340, 509	20.00

∐oal +h	Financial Systems FAYETTE COUNTY	HUSDI TAI	In Lio	u of Form CMS-2	0552 10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	Worksheet M-3	
SERVI C		Component CCN: 14-8527	From 07/01/2022 To 06/30/2023	Date/Time Pre	pared:
-		Title XVIII	RHC I	11/29/2023 3: Cost	06 pm
			1	3331	
				1. 00	
1 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES	Wist M 2 15 - 20)		1 750 070	1 00
1. 00 2. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro Cost of injections/infusions and their administration (from W			1, 759, 870 0	1. 00 2. 00
3. 00	Total allowable cost excluding injections/infusions (line 1 m			1, 759, 870	3.00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			10, 529	4. 00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00
6. 00	Total adjusted visits (line 4 plus line 5)			10, 529	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	167.15	7.00
			Carcuration	OI LIMIT (I)	
			Rate Period 1	Rate Period 2	
			(07/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	06/30/2023) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20), 6 or vour contractor)	266. 22	276. 34	8.00
9. 00	Rate for Program covered visits (see instructions)	, , , , , , , , , , , , , , , , , , ,	167. 15		
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		777	722	
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr	•	129, 876 0	120, 682 0	11. 00 12. 00
13. 00	Program covered cost from mental health services (line 9 x li		0	0	13.00
14. 00	Limit adjustment for mental health services (see instructions	•	0	0	14. 00
15.00	Graduate Medical Education Pass Through Cost (see instruction	•			15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	250, 558	•
16. 01	Total program charges (see instructions) (from contractor's re			358, 624	•
16. 02 16. 03	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times	•		23, 165 16, 185	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0)	•		177, 435	•
	(Titles V and XIX see instructions.)	, , , , , , , , , , , , , , , , , , , ,		,	
16. 05	Total program cost (see instructions)		0	193, 620	
17.00	Primary payer amounts	(6		12.570	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(Troil contractor		12, 579	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		64, 576	19. 00
	records)	, ,			
20.00	Net Medicare cost excluding vaccines (see instructions)			193, 620	•
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		0 193, 620	21.00
22. 00 23. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			193, 620	22. 00 23. 00
23. 01	` '			0	23. 01
24.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	_		0	
	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	
25. 99 26. 00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 193, 620	
26. 01	Seguestration adjustment (see instructions)			3, 872	
26. 02	, ,			0	
27. 00	1 3			309, 417	•
	Tentative settlement (for contractor use only)	00 07 00)		110 ((0	28. 00
29. 00 30. 00	Balance due component/program (line 26 minus lines 26.01, 26. Protested amounts (nonallowable cost report items) in accorda	•		-119, 669 0	•
30.00	chapter I, §115.2	mice with owe rup. 19-11	'		30.00
	· · · · · · · · · · · ·				•

near th	Financial Systems FAYETTE COUNTY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-1346	Peri od:	Worksheet M-3	
SERVI (ES	Component CCN: 14-8528	From 07/01/2022 To 06/30/2023	Date/Time Pre	nared:
		Component Con. 14-6526	10 00/30/2023	11/29/2023 3:	
		Title XVIII	RHC II	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		345, 509	1.00
2.00	Cost of injections/infusions and their administration (from W	kst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		345, 509	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1, 208	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		1 200	5.00
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			1, 208 286. 02	6. 00 7. 00
7.00	Adjusted cost per visit (iffie 3 divided by iffie 6)		Cal cul ati on		7.00
			Carcuration	OI LIMIT (I)	
			Rate Period 1	Rate Period 2	
			(07/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	06/30/2023) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your contractor)	473. 21	491. 19	8. 00
9. 00	Rate for Program covered visits (see instructions)		286. 02	286. 02	1
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		107	155	1
11.00	Program cost excluding costs for mental health services (line		30, 604	44, 333	1
12.00	Program covered visits for mental health services (from contr	,	0	0	
13. 00 14. 00	Program covered cost from mental health services (line 9 x li Limit adjustment for mental health services (see instructions	,	0	0	13. 00 14. 00
15. 00	Graduate Medical Education Pass Through Cost (see instruction	,	ď	O .	15.00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	,	o	74, 937	
16.01	Total program charges (see instructions) (from contractor's re	•		62, 913	
16. 02	Total program preventive charges (see instructions)(from prov	•			16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			4, 613	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		52, 919	16.04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	57, 532	16 05
17. 00	Pri mary payer amounts			07,002	l
18.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		4, 175	18. 00
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		10, 973	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			57, 532	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		37, 332	ı
22. 00	,	,		57, 532	
23.00	Allowable bad debts (see instructions)			0	1
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24. 00		ructions)		0	
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	->		0	25.00
25. 99	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	5)		0	•
26. 00	, , , , , , , , , , , , , , , , , , , ,			57, 532	1
26. 01	Sequestration adjustment (see instructions)			1, 151	
26. 02	1 '			0	26. 02
27. 00	Interim payments			97, 343	
28.00	,	00 07 50		0	28.00
00 00	Balance due component/program (line 26 minus lines 26.01, 26.	U2, 27, and 28)		-40, 962	J 29.00
29. 00 30. 00		nco with CMS Dub 1E II	I	0	30.00

Health Financial Systems	FAYETTE COUNTY I	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 14-1346 Component CCN: 14-8527	From 07/01/2022	Worksheet M-5 Date/Time Prepared: 11/29/2023 3:06 pm
			DUC I	C+

		p		11/29/2023 3:0	06 pr
			RHC I	Cost	•
			Par	t B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			309, 417	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	3.
02				0	3.
03				0	3.
04				0	3.
05				0	3.
	Provider to Program				
50				0	3.
51				0	3
52				0	3.
53				0	3
54				0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		309, 417	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	k review. Also show date of	F		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	5
02				0	5.
03				0	5
	Provider to Program				
50				0	5.
51				0	5
52				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)				6
01	SETTLEMENT TO PROVIDER			0	6
02	SETTLEMENT TO PROGRAM			119, 669	6
00	Total Medicare program liability (see instructions)			189, 748	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
00	Name of Contractor				8.

Health Financial Systems	FAYETTE COUNTY	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 14-1346 Component CCN: 14-8528	From 07/01/2022	
			DUC 11	Coct

		Component Con. 14-6326	10 00/30/2023	11/29/2023 3: (
			RHC II	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
00	Total interim payments paid to hospital-based RHC/FQHC			97, 343	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		o	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount	based on subsequent			3
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
)1				0	3
)2				0	3
)3				0	3
04				0	3
05				0	3
	Provider to Program				
50				0	3
51				0	3
52				0	3
53				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		97, 343	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				_
00	List separately each tentative settlement payment after des	k review. Also show date o	OT		5
	each payment. If none, write "NONE" or enter a zero. (1) Program to Provider				
)1	Program to Provider			0	5
)2					5
)3					5
	Provider to Program			0	~
50	110videi to 110gidiii			0	5
51				0	5
2				l ol	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)				6
)1	SETTLEMENT TO PROVIDER			o	6
)2	SETTLEMENT TO PROGRAM			40, 962	6
00	Total Medicare program liability (see instructions)			56, 381	7
	(300 1101 431 310)		Contractor	NPR Date	É
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
	Name of Contractor				8