ADDENDUM 1

DATE:	July 13, 2016
PROJECT:	Financial Assurance Validation
RFP NO:	744-R1620
OWNER:	The University of Texas Health Science Center at Houston
TO:	Prospective Proposers

This Addendum forms part of and modifies Bid Documents dated, June 20, 2016, with amendments and additions noted below.

The following questions were submitted before the deadline. The responses are in red.

- Are the investments held and managed by UTIMCO or an independent investment manager and if so who?
 Investments are held and managed by UTIMCO.
- 2. For the contracts with the Authority for inpatient services for voluntary or civil commitment process, inpatient competency restoration services and mental health inpatient services:
 - a. Can you describe the reimbursement mechanism cost reimbursement, per day, % of charges etc.?
 For inpatient indigent care services (voluntary and civil commitment): the hospital is paid an annual amount for 171 beds at \$513 per bed day, with a contractual occupancy requirement of 92% to 95%.
 For competency restoration services: the hospital is paid per occupied patient day, invoiced monthly.
 - b. Any compliance requirements that need to be tested by BV as part of this contract?
 The contract with The Harris Center includes a requirement for an audited financial statement of revenues received and expenses incurred.
- 3. For the contract with the Harris County Juvenile Probation Department
 - a. Can you describe the reimbursement mechanism cost reimbursement, per day, % of charges etc.?
 The hospital is paid \$3,200,000 per year for a 21 bed unit.
 - Any compliance requirements that need to be tested by BV as part of this contract?
 There are none.

4. What is the basis for the state appropriation for employee health insurance costs? Is it a percentage of payroll, amount per employee?

A. State Contribution to Group Insurance for Higher Education Employees Participating in the Employees Retirement System Group Benefits Program.

Funds identified and appropriated above for group insurance are intended to fund:

1. the majority of the cost of the basic life and health coverage for all active and retired employees; and

2. fifty percent of the total cost of health coverage for the spouses and dependent children of all active and retired employees who enroll in coverage categories which include a spouse and/or dependent children. In no event shall the total amount of state contributions allocated to fund coverage in an optional health plan exceed the actuarially determined total amount of state contributions that would be required to fund basic health coverage for those active employees and retirees who have elected to participate in that optional health plan. Funds appropriated for higher education employees' group insurance contributions may not be used for any other purpose. It is further provided that institutions shall cooperate so that employees employed by more than one institution may be covered under one group policy and that said policy may be held jointly by two or more institutions and paid from funds appropriated to the institutions for payment of employee insurance premiums as set out above.

B. The University of Texas System Group Health Insurance Contributions.

Funds identified and appropriated above for group insurance are intended to fund a comparable portion of the costs of basic health coverage for all active and retired employees and their dependents as is provided above for higher education active and retired employees and dependents participating in the Employees Retirement System's Group Benefits Program. In no event shall the total amount of state contributions allocated to fund coverage in an optional health plan exceed the actuarially determined total amount of state contributions that would be required to fund basic health coverage for those active employees and retirees who have elected to participate in that optional health plan. Funds appropriated for higher education employees' group insurance contributions may not be used for any other purpose. The University of Texas System shall file a report with the Legislative Budget Board, the Governor and the Comptroller by September 15 of each year, detailing all group health insurance plans offered to system employees and retirees, including the benefit schedule, premium amounts, and employee/retiree contributions. Active and retired employees of The University of Texas System are authorized to use one-half of the "employee-only" state contribution amount for optional insurance. Optional insurance for the employees participating in the group insurance program shall be defined by The University of Texas System. Active and retired employees participating in these plans may only use one-half of the employeeonly state contribution if they sign and submit a document to their employing institution indicating they have health insurance coverage from another source.

- Please provide the Medicare and Medicaid cost report for 2015 for HCPC.
 Please see EXHIBIT 1 Medicare and Medicaid Cost Report for 2015 for HCPC (79 pages) below.
- Please provide a balance sheet for each of the funds as of August 31, 2015. Please see EXHIBIT 2 - HCPC Balance Sheet as of August 31, 2015 (5 pages) and EXHIBIT 3 - HCPC Balance Sheet DESIGNATED FUNDS as of August 31, 2015 (4 pages) below.
- What is the total projected amount of capital expenditures for fiscal 2016 since you indicated that you had significant capital projects? We expect to spend approximately \$1.5 million in fiscal year 2016.
- 8. Where there any audit adjustments in 2015 and if so what for? There were no audit adjustments in fiscal year 2015.
- Why Is HCPC going out for bid? Have there been any disagreements with the current auditors?
 There have been no disagreements with current auditors. HCPC is going out for bid due to university procurement requirements.
- 10. During the three week fieldwork how many people were onsite full time? During the three week fieldwork, anywhere from one to four auditors were onsite at one time; and only two were onsite full time.
- 11. The HUB pre-Bid Agenda indicates that the contract is expected to be greater than \$100,000 is this for one year or multiple years of the engagement or for any additional services?

This bid may result in a multi-year award. Please note, the HUB plan must be completed for this project even if your bid will not be \$100,000.00 or greater or it will be disqualified.

12. Can you please provide a copy of the August 2015 audited financial statements for HCPC?

Yes. Please see EXHIBIT 4 - UTHealth HCPC 2015 Fin Stnts w Audit Opinion (final) (13pages) below.

EXHIBIT 1 - Medicare and Medicaid Cost Report for 2015 for HCPC

Heal th	Financial Systems	H	IARRIS CO PSYCHI	ATRIC CENTER		In Lie	u of Form CMS-	2552-10
		y Law (42 USC 1395g; 42 CFF						
		eginning of the cost repor			payments (42	USC 1395g).	OMB NO. 0938-	0050
		TH CARE COMPLEX COST REPOR	RT CERTIFICATIO	N Provider	CCN: 454076	Peri od:	Worksheet S	
AND SE	TTLEMENT SUMMARY					From 09/01/2014 To 08/31/2015	Parts I-III Date/Time Pre	nared
						10 00/31/2013	1/28/2016 12:	
PART I	- COST REPORT STATU	JS						
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use on	ly 2.[]Man	ually submitted cost repor	t					
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	(5) Ameno							
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PART I	I - CERTIFICATION							
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	CERTIFICA	ATION BY OFFICER OR ADMINIS	STRATOR OF PROVI	DER(S)				
		that I have read the above						
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	Cost Center De	escription	Title V	Part A	Part B	HIT	Title XIX	
			1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEME	NT SUMMARY	_1					4
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2.00	Subprovider - IPF		0	0		0	0	
3.00	Subprovider - IRF		0	0		0	0	
5.00	Swing bed - SNF		0	0	1	U	0	5.00

Swing bed - SNF Swing bed - NF 5.00 000000 6.00 8.00 NURSING FACILITY RURAL HEALTH CLINIC I 10.00 0 11.00 FEDERALLY QUALIFIED HEALTH CENTER I 0 0 200.00 Total 0 -34,092 1,263

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

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	Separately Certified ASC										13
	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14
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	Cost Reporting Period (mm/dd/yyyy)						09/01/	•	08/31/2	2015	20
00	Type of Control (see instructions) Inpatient PPS Information							9			21
00	Does this facility qualify and is it	currently receivi	ng paymen	ts for c	li sprop	ortionate	N		N		22
	share hospital adjustment, in accorda										
	for yes or "N" for no. Is this facili amendment hospital?) In column 2, ent				06(c)(2	2) (Pi ckl e					
	Did this hospital receive interim unc				cost re	eporting	N		N		22
	period? Enter in column 1, "Y" for ye	es or "N" for no f	for the po	rtion of	the co	ost					
	reporting period occurring prior to C for no for the portion of the cost re										
	(see instructions)	porting period oc	curring o	n or art							
	Is this a newly merged hospital that						N		Ν		22
	determined at cost report settlement?						s				
	or "N" for no, for the portion of the in column 2, "Y" for yes or "N" for r						n				
	or after October 1.					P					
	Did this hospital receive a geographi								N		22.
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for r										
	prior to October 1. Enter in column 2	, "Y" for yes or	"N" for n	o for th	e porti	on of th	e				
	cost reporting period occurring on or						h				
	hospital contain at least 100 but not 42 CFR 412.105)? Enter in column 3, "			unted Ir	i accor(Lance WIT	"				
00	Which method is used to determine Mec	licaid days on lir	nes 24 and					3	Ν		23.
	1, enter 1 if date of admission, 2 if										
	method of identifying the days in thi used in the prior cost reporting peri										
			In-State	In-Sta	te 0	ut-of	Out-of	Medi ca		her	
			Medicaid	Medica eligib		State	State	HMO da	<i>y</i>	cai d	
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	If this provider is an IPPS hospital, in-state Medicaid paid days in columr		0		0	0	0		0	0	24
	Medicaid eligible unpaid days in colu										
	out-of-state Medicaid paid days in co	lumn 3,									
	out-of-state Medicaid eligible unpaid										
	 Medicaid HMO paid and eligible but column 5, and other Medicaid days in 										
00	If this provider is an IRF, enter the	in-state	0		0	0	о		0		25
	Medicaid paid days in column 1, the i										
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HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ΑΤΑ	Provi der		eriod: rom 09/01/ p 08/31/	/2015	Workshe Part I Date/Ti 1/28/20	me Pre	pared:
					Urban/Rur 1.00	al S		Geogr	
26.00	Enter your standard geographic classification (not w			ginning of the	1.00	1	2.0		26.00
27.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban c	age) st or "2" f	atus at the end or rural. If ap			1			27.00
35. 00	enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter th effect in the cost reporting period.			CH status in		0			35.00
					Begi nni 1. 00		Endi 2. (-
36.00	Enter applicable beginning and ending dates of SCH s		Subscript line	36 for number	1.00		2.0		36.00
37.00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.		umber of period	ds MDH status		0			37.00
38.00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number c enter subsequent dates.								38.00
					Y/N 1.00		Y/ 2.0		-
39.00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet the mileage re CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	i)? Énte equireme	er in column 1 nts in accordar	"Y" for yes nce with 42	N		N		39.00
40.00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	on adjus ober 1.	tment? Enter "\ Enter "Y" for y	(" for yes or	N		N		40.00
						V 1.00	2. 00	XI X 3.00	
45.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme	ent for	di sproporti onat	te share in acc	ordance	N	N	N	45.00
46.00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	N	46.00
47. 00 48. 00	Is this a new hospital under 42 CFR §412.300 PPS cap Is the facility electing full federal capital paymer Teaching Hospitals				10.	N N	N N	N N	47.00 48.00
56.00	Is this a hospital involved in training residents in or "N" for no.	approv	ed GME programs	s? Enter "Y" f	or yes	Y			56.00
57.00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mor for yes or "N" for no in column 2. If column 2 is "	or yes o oth of t Y", com	r "N" for no ir his cost report plete Worksheet	n column 1. If ting period? E	column 1 Inter "Y"	N			57.00
58.00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	nburseme	nt for physicia	ans' services a	IS	N			58.00
	Are costs claimed on line 100 of Worksheet A? If ye	es, comp	lete Wkst. D-2,			N			59.00
60.00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"				tions)	N	Di rect	t GME	60.00
		1.00	2.00	3.00	4.00		5.0		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00		0.00	61.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.00					61. 01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of	è	0.00	0.00					61.02
61.03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for		0.00	0.00					61. 03
61. 04	determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00					61. 04
61. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line	2	0.00	0.00					61. 05
61.06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00					61.06

HOSPI TAL	AND HOSPITAL HEALTH CARE COMPL	_EX IDENTIFICATION DA	ТА	Provi der		eriod: rom 09/01/2014 o 08/31/2015	Worksheet S-2 Part I Date/Time Pre 1/28/2016 11:3	pared:
			Program	n Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. (00	2.00	3.00	4.00	
spa for col pra um FTI 61. 20 Of pra res i ns en 3,	the FTEs in line 61.05, speci ecialty, if any, and the numbe r each new program. (see instr lumn 1, the program name, ente ogram code, enter in column 3, weighted count and enter in co E unweighted count. The FTEs in line 61.05, speci ogram specialty, if any, and t sidents for each expanded prog structions) Enter in column 1, ter in column 2, the program c the IME FTE unweighted count direct GME FTE unweighted count	r of FTE residents uctions) Enter in r in column 2, the the IME FTE lumn 4, direct GME fy each expanded he number of FTE ram. (see the program name, ode, enter in column and enter in column				0.00		61. 10
100	A Droui ol opo Affection the U	1th Decourses and C	nd ooo Artri	lotnet!			1.00	
	A Provisions Affecting the Hea ter the number of FTE resident					od for which	0.00	62.00
	ur hospital received HRSA PCRE				i opor ti ng por i		0100	
dui	ter the number of FTE resident ring in this cost reporting pe aching Hospitals that Claim Re	riod of HRSA THC prog	ram. (see i			your hospital	0.00	62.01
53.00 Has	s your facility trained reside " for yes or "N" for no in col	nts in nonprovider se	ettings duri		instructions)		N	63.00
					Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					1.00	2.00	3.00	
	ction 5504 of the ACA Base Yea				This base year	is your cost r	eporting	
64.00 En ⁻ in res se ⁻ res	riod that begins on or after J ter in column 1, if line 63 is the base year period, the num sident FTEs attributable to ro ttings. Enter in column 2 the sident FTEs that trained in yo (column 1 divided by (column)	yes, or your facilit ber of unweighted non tations occurring in number of unweighted ur hospital. Enter in 1 + column 2)). (see	y trained r p-primary ca all nonprov non-primar column 3 t instruction	residents nre Mider Ty care The ratio	0.00			
		Program Name	Progran	n Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2. (00	3.00	4.00	5.00	
is tra yea FTI pro the col unn res ro ro col	ter in column 1, if line 63 yes, or your facility ained residents in the base ar period, the program name sociated with primary care Es for each primary care ogram in which you trained sidents. Enter in column 2, e program code, enter in lumn 3, the number of weighted primary care FTE sidents attributable to tations occurring in all n-provider settings. Enter in lumn 4, the number of weighted primary care sident FTEs that trained in				0. 00) 0.00	0. 000000	

Heal th	Financial Systems	HARRIS CO	D PSYCHI ATRI	C CENTER		I	n Lie	u of For	m CMS-2	2552-10
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					Unwei ghted FTEs Nonprovi der Si te	Unwei gh FTEs Hospi t	in al	Ratio (c (col. 1 2)	:ol. 1/ + col.)	
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovide	r Settina	1.00 httpsEffective f	2.00 For cost re		3.C na perio		
	beginning on or after July 1, 20	10	•	0			•	<u> </u>		
	Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider setti ry care resid 3 the ratio d	ngs. dent	0.0		0. 00	0.	000000	66.00
		Program Name	Program	Code	Unwei ghted FTEs Nonprovi der Si te	Unwei gh FTEs Hospi t	in	Ratio (c (col. 3 4)	+ col.	
		1.00	2.0	0	3.00	4.00)	5. C	0	
	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.0	0	0.00	0.	000000	67.00
	Inpatient Psychiatric Facility P	PS					1.00) 2.00	3.00	
70.00	Is this facility an Inpatient Ps	ychiatric Facility (I	PF), or does	s it cont	ain an IPF sub	provi der?	Y			70.00
71.00	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Inpatient Rehabilitation Facilit	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye)04? Enter ' lity train ı)(D)? Enter '	'Y" fory residents 'Y" for y	ves or "N" for in a new teac ves or "N" for	no. (see hi ng no.	Y	N	0	71.00
75.00	Is this facility an Inpatient Re	habilitation Facility	(IRF), or a	does it c	ontain an IRF		N			75.00
76.00	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	ember 15, 200 new teaching for no. Colu)4? Enter g program umn 3: If	"Y" for yes o in accordance column 2 is Y	r "N" for with 42			0	76. 00
								1. C	0	
80. 00 81. 00	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers					period? E	nter	N		80. 00 81. 00
85. 00 86. 00	Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider ((excl uded uni				no.	N		85. 00 86. 00
87.00	Is this hospital a "subclause (I for yes or "N" for no.			n 1886(d)	(1)(B)(iv)(II)	? Enter "Y		N		87.00
	yes of in tot no.					V		XL	X	
	Title V and XIX Services					1.00)	2.0	0	
90.00	Does this facility have title V		hospital ser	rvi ces? E	nter "Y" for	N		Y		90.00
91.00	yes or "N" for no in the applica Is this hospital reimbursed for	title V and/or XIX th				N		Y		91.00
	full or in part? Enter "Y" for y Are title XIX NF patients occupy							N		92.00
	instructions) Enter "Y" for yes	or"N" for no in the	applicable of	column.		NJ				
	Does this facility operate an IC "Y" for yes or "N" for no in the	applicable column.				N		N		93.00
	Does title V or XIX reduce capit applicable column.	al cost? Enter "Y" fo	or yes, and '	'N" for n	o in the	Y		Y		94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	ATRIC CENTER	CON 45407/		n Lieu		MS-2552-10
	Provi der		Period: From 09/01/ Fo 08/31/		Worksheet Part I Date/Time	Prepared:
			V		1/28/2016 XI X	11:28 am
95.00 If line 94 is "Y", enter the reduction percentage in the app	olicable colum	n.	1.00	5.80	2.00	5.80 95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	s or "N" for n	o in the	Y		Y	96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	olicable colum	n.		10.00	1(0.00 97.00
105.00 Does this hospital qualify as a critical access hospital (CA 106.00 If this facility qualifies as a CAH, has it elected the all-		hod of payment	N			105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see inst	ructions) If	N			107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dule? See 42	Ν			108.00
	Physi cal 1.00	Occupational 2.00	Speecl 3.00		Respirato 4.00	ory
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N	109.00
					1.00	
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (41	OA Demo)for	-	Ν	110.00
				1.00	2.00 3.	00
Miscellaneous Cost Reporting Information	a "N" for no is	n oolumn 1. If	column 1	N		0 115.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	If column 2 nt for long te	is "E", enter rm care (inclu	in column des	N		0 115.00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insur			"N" for	N N		116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence pol	icy? Enter 1	if the policy	is	0		118.00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	6	Insuranc	e
118.01List amounts of malpractice premiums and paid losses:		1.00	2.00	0	3.00	0118.01
		1				0110.01
118.02 Are malpractice premiums and paid losses reported in a cost						
	center other	than the	1.00 N		2.00	118. 02
Administrative and General? If yes, submit supporting scheo and amounts contained therein.					2.00	
Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00DO NOT USE THIS LINE 120.00Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmer	dule listing c d Harmless pro n column 1, "Y ualifies for th	ost centers vision in ACA " for yes or he Outpatient			2.00 N	118. 02 119. 00 120. 00
 Administrative and General? If yes, submit supporting schedand amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implapatients? Enter "Y" for yes or "N" for no. 	dule listing c d Harmless prov n column 1, "Y ualifies for t nts? (see inst	ost centers vision in ACA " for yes or he Outpatient ructions)	N			119.00
Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	dule listing co d Harmless prov n column 1, "Y ualifies for th nts? (see inst antable device:	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to	N			119. 00 120. 00
Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, er	dule listing of d Harmless pro- n column 1, "Y ualifies for ti nts? (see inst antable device: pr yes and "N" nter the certi	vision in ACA " for yes or he Outpatient ructions) s charged to	N N N			119. 00 120. 00 121. 00
 Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyy) below. 126.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 	dule listing of d Harmless pro- n column 1, "Y ualifies for th nts? (see inst antable devices or yes and "N" nter the certif 2. ter the certif	vision in ACA "for yes or he Outpatient ructions) s charged to for no. If fication date	N N N			119.00 120.00 121.00 125.00
 Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implatients? Enter "Y" for yes or "N" for no. 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 	dule listing of d Harmless pro- n column 1, "Y ualifies for th hts? (see inst antable devices or yes and "N" nter the certif 2. ter the certif 2. ter the certif	vision in ACA " for yes or he Outpatient ructions) s charged to for no. If fication date ication date	N N N			119.00 120.00 121.00 125.00 126.00
Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implat patients? Enter "Y" for yes or "N" for no. 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2	dule listing of d Harmless pro- n column 1, "Y ualifies for th nts? (see inst antable device: pr yes and "N" nter the certif 2. ter the certif 2.	vision in ACA " for yes or he Outpatient ructions) s charged to for no. If fication date ication date	N N N			119.00 120.00 121.00 125.00 126.00 127.00
 Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implatients? Enter "Y" for yes or "N" for no. 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 130.00 If this is a Medicare certified liver transplant center, enter 	dule listing of d Harmless pro- n column 1, "Y ualifies for th nts? (see inst antable devices or yes and "N" nter the certif 2. ter the certif 2. er the certific enter the certific	vision in ACA " for yes or he Outpatient ructions) s charged to for no. If fication date ication date cation date in	N N N			119.00 120.00 121.00 125.00 126.00 127.00 128.00
 Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implatients? Enter "Y" for yes or "N" for no. 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, ent in column 1 and termination date, if applicable, in column 2 130.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2 	dule listing of d Harmless pro- n column 1, "Y ualifies for th hts? (see inst- antable devices or yes and "N" nter the certific ter the certific en the certific enter the certific enter the certific enter the certific	vision in ACA " for yes or he Outpatient ructions) s charged to for no. If fication date ication date ication date in tification	N N N			119.00 120.00 121.00 125.00 126.00 127.00 128.00 129.00
 Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyy) below. 126.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2 130.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2 130.00 If this is a Medicare certified lung transplant center, date in column 1 and termination date, if applicable, in column 2 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2 130.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 2 	dule listing of d Harmless pro- n column 1, "Y ualifies for th nts? (see inst antable devices or yes and "N" nter the certific ter the certific enter the certific enter the certific ter the certific enter the certific umn 2. r, enter the certific ter the certific	vision in ACA " for yes or he Outpatient ructions) s charged to for no. If fication date ication date ication date in tification ertification	N N N			119.00 120.00 121.00 125.00 126.00 127.00 128.00 129.00 130.00
 Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implatients? Enter "Y" for yes or "N" for no. 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 130.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2 130.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2 130.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2 131.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2 	dule listing of d Harmless pro- n column 1, "Y ualifies for th hts? (see inst- antable devices or yes and "N" nter the certifie ter the certifie enter the certifie enter the certifie umn 2. r, enter the certifie ter the certifie ter the certifie contact the certifie ter the certifie ter the certifie	vision in ACA " for yes or he Outpatient ructions) s charged to for no. If fication date ication date cation date in tification ertification ication date	N N N			119.00 120.00 121.00 125.00 126.00 127.00 128.00 129.00 130.00 131.00

Health Financial Systems	HARRIS CO PS	YCHI ATRI C CENTER		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der		Period:	Worksheet S-2	
				rom 09/01/2014 o 08/31/2015	Part I Date/Time Pre	pared:
					1/28/2016 11:	
				1.00	2.00	-
Al I Provi ders				1.00	2.00	
140.00 Are there any related organization				Y		140.00
chapter 10? Enter "Y" for yes or "						
are claimed, enter in column 2 the		per. <u>(see instruc</u> 2.00	tions)	3.00		
If this facility is part of a chai			ugh 143 the na		of the	
home office and enter the home off	<u>ice contractor name and</u>	d contractor numb				
141.00 Name: UT HEALTH SCIENCE CENTER	Contractor's Name:	NOVITAS	Contracto	r's Number: 0401	1	141.00
142. 00 Street: 143. 00 Ci ty:	PO Box: State:		Zin Codo			142.00
143. 00 c1 ty:	jstate:		Zip Code:			143.00
					1.00	-
144.00 Are provider based physicians' cos	ts included in Workshee	et A?			Y	144.00
				1.00		_
145.00 If costs for renal services are cl	aimed on Wkst A line	74 are the cost	s for	1.00 N	2.00	145.00
inpatient services only? Enter "Y"				IN		145.00
no, does the dialysis facility inc	lude Medicare utilizati					
period? Enter "Y" for yes or "N"						
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in				N		146.00
yes, enter the approval date (mm/d		J. 15-2, Chapter	40, 94020) 11			
					1.00	
147.00 Was there a change in the statisti 148.00 Was there a change in the order of					N N	147.00 148.00
149.00 Was there a change to the simplifi				no	N	148.00
	ou cost innanng mothour	Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provi						
or charges? Enter "Y" for yes or " 155.00Hospital	N TOP NO FOF each comp	N	N	<u>See 42 CFR 9413</u> N	N	155.00
156.00 Subprovi der – IPF		N	N	N	N	156.00
157.00 Subprovider - IRF		N	N	N	N	157.00
158. 00 SUBPROVI DER						158.00
159.00 SNF 160.00 HOME_HEALTH_AGENCY		N	N N	N N	N N	159.00 160.00
161. 00 CMHC		IN	N	N	N	161.00
			1			
					1.00	
Multicampus 165.00 s this hospital part of a Multica	mous bospital that has	000 0F 00F0 0000	ucoc in diffor	opt CRSAc2	N	165.00
Enter "Y" for yes or "N" for no.	ilipus nospi tai that nas	one or more camp		ent CDSAS?	IN	105.00
	Name	County		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					0.00	166.00
0, county in column 1, state in						
column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						
					1.00	-
Health Information Technology (HIT) incentive in the Ame	rican Recovery an	d Reinvestment	Act		
167.00 Is this provider a meaningful user					N	167.00
168.00 If this provider is a CAH (line 10			e 167 is "Y"),	enter the	(168.00
reasonable cost incurred for the H 168.01 f this provider is a CAH and is n			r qualify for	a hardshi n		168.01
exception under §413.70(a)(6)(ii)?				a naraoni p		
169.00 If this provider is a meaningful u	iser (line 167 is "Y") a			N"), enter the	0.00	169.00
transition factor. (see instructio	ins)			Deri	E a all	
				Begi nni ng 1. 00	Endi ng 2.00	-
170.00 Enter in columns 1 and 2 the EHR b	eginning date and endir	ng date for the r	eporting	1.00	2.00	170.00
period respectively (mm/dd/yyyy)		C	. 5			

Health Financial Systems	HARRIS CO PSYCHIATE	RIC CENTER	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DATA	Provider CCN: 454076	From 09/01/2014	Worksheet S-2 Part I Date/Time Pre 1/28/2016 11:	epared:
				1.00	
171.00 If line 167 is "Y", does this pr				N	171.00
Medicare cost plans reported on (see instructions)	Wkst. S-3, Pt. I, line 2, col.	6? Enter "Y" for yes a	nd "N" for no.		

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 454076	Period: From 09/01/2014	Worksheet S- Part II	2
					To 08/31/2015	Date/Time Pr	
	· · · · · · · · · · · · · · · · · · ·				Y/N	1/28/2016 11 Date	: 28 ar
					1.00	2.00	
	General Instruction: Enter Y for all YES resp	oonses. Enter N for	all NO re	esponses. Ente	r all dates in	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS						_
	Provider Organization and Operation						-
00	Has the provider changed ownership immediatel				Ν		1.
	reporting period? If yes, enter the date of t	the change in colum	n 2. (see	- · · · · · · · · · · · · · · · · · · ·		N//1	_
				Y/N 1.00	Date 2.00	V/I 3.00	
00	Has the provider terminated participation in	the Medicare Progr	am?lf	N N	2.00	3.00	2.
	yes, enter in column 2 the date of termination	on and in column 3,	"V" for				
00	voluntary or "I" for involuntary. Is the provider involved in business transact	tions including ma	nagement	Y			3.
0	contracts, with individuals or entities (e.g.	, chain home offic	es, drug				J.
	or medical supply companies) that are related	d to the provider c	or its				
	officers, medical staff, management personnel						
	of directors through ownership, control, or 1 relationships? (see instructions)	raming and other si	miiar				
	· · · · · · · · · · · · · · · · · · ·			Y/N	Туре	Date	
				1.00	2.00	3.00	
0	Financial Data and Reports Column 1: Were the financial statements prep	pared by a Certifie	d Public	N			4.
0	Accountant? Column 2: If yes, enter "A" for						– – – –
	or "R" for Reviewed. Submit complete copy or		lein				
0	column 3. (see instructions) If no, see inst Are the cost report total expenses and total		from	N			5.
0	those on the filed financial statements? If			IN IN			5.
		· · ·		-	Y/N	Legal Oper.	
	Approved Educational Activitica				1.00	2.00	
0	Approved Educational Activities Column 1: Are costs claimed for nursing scho	ol?Column 2. If	ves is th	ne provider is	N		6.
0	the legal operator of the program?		Joo! 10 ti				
0	Are costs claimed for Allied Health Programs				N		7.
0	Were nursing school and/or allied health prog cost reporting period? If yes, see instruction		or renewed	during the	N		8.
0	Are costs claimed for Interns and Residents i		luate medio	cal education	Y		9.
	program in the current cost report? If yes, s						
00	Was an approved Intern and Resident GME progr		enewed in 1	the current	N		10.
00	cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center		in an App	proved	Ν		111.
	Teaching Program on Worksheet A? If yes, see						
						Y/N	
	Bad Debts					1.00	
	Bad Debts Is the provider seeking reimbursement for bac	d debts? If yes, se	e instruct	ti ons.		1.00 Y	12.
00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det				st reporting	1	
00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy.	ot collection polic	cy change o	during this co		Y N	13.
00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a	ot collection polic	cy change o	during this co		Y	13.
00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy.	ot collection polic	y change o	during this co ⁻ yes, see ins	tructions.	Y N N	13. 14.
00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	ot collection polic and/or co-payments pr cost reporting p	waived? If	during this co * yes, see ins yes, see inst	ructions.	Y N N Y Part B	13. 14.
00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? If	during this co f yes, see ins yes, see inst Pa Y/N	ructions.	Y N N Part B Y/N	13. 14.
00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	ot collection polic and/or co-payments pr cost reporting p	waived? If	during this co * yes, see ins yes, see inst	ructions.	Y N N Y Part B	13. 14.
00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the price PS&R Data Was the cost report prepared using the PS&R	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? If	during this co f yes, see ins yes, see inst Pa Y/N	ructions.	Y N N Part B Y/N	13. 14. 15.
00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes,	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? If	during this co yes, see inst yes, see inst Pa Y/N 1.00	ructions.	Y N N Y Part B Y/N 3.00	13. 14. 15.
00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? If	during this co yes, see inst yes, see inst Pa Y/N 1.00	ructions.	Y N N Y Part B Y/N 3.00	13. 14. 15.
00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? If	during this co yes, see inst yes, see inst Pa Y/N 1.00	ructions.	Y N N Y Part B Y/N 3.00	13. 14. 15. 16.
00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? If	during this co yes, see inst yes, see inst Pa Y/N 1.00	ructions.	Y N N Y Part B Y/N 3.00	13. 14. 15. 16.
00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? If	Juring this co	ructions.	Y N N Part B Y/N 3.00	13. 14. 15. 16.
00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 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	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? If	Juring this co	ructions.	Y N N Part B Y/N 3.00	13. 14. 15. 16.
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 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)	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? If	Juring this co	ructions.	Y N N Part B Y/N 3.00 Y	13. 14. 15. 16. 17.
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? If	Juring this co	ructions.	Y N N Part B Y/N 3.00	13. 14. 15. 16. 17.
00 00 00 00 00 00 00 00 00 00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 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)	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? If	Juring this co	ructions.	Y N N Part B Y/N 3.00 Y	13. 14. 15. 16. 17.
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? If	Juring this co	ructions.	Y N N Part B Y/N 3.00 Y	13. 14. 15. 16. 17.
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? If	Juring this co	ructions.	Y N N Part B Y/N 3.00 Y N N	13. 14. 15. 16. 17. 18.
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to T7 is yes, were adjustments Here the paid the power used to file this cost report? If yes, were adjustments If line 16 or 17 is yes, were adjustments Here the paid the power used to file this cost report? If yes, were adjustments If line 16 or 17 is yes, were adjustments	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? If	Juring this co	ructions.	Y N N Part B Y/N 3.00 Y	13. 14. 15. 16. 17. 18.
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? If	Juring this co	ructions.	Y N N Part B Y/N 3.00 Y N N	13. 14. 15. 16. 17. 18.
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this 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 data for corrections of other PS&R Report information? If yes, see instructions.	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? If	Juring this cc yes, see inst yes, see inst Pa Y/N 1.00 Y N N N	ructions.	Y N N Part B Y/N 3.00 Y N N N	13. 14. 15. 16. 17. 18. 19.
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this 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	ot collection polic and/or co-payments or cost reporting p Descriptic 0	waived? If	Juring this co	ructions.	Y N N Part B Y/N 3.00 Y N N	12. 13. 14. 15. 16. 17. 18. 19. 20.

Heal th	Financial Systems	ARRIS CO PSYCH	IATRIC CENTER		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		eriod:	Worksheet S-2	
					rom 09/01/2014 o 08/31/2015	Part II Date/Time Pre	pared.
						1/28/2016 11:	
					rt A	Part B	
			iption D	Y/N 1.00	Date 2.00	Y/N 3.00	
21.00	Was the cost report prepared only using the		J	N 1.00	2.00	3.00 N	21.00
21.00	provider's records? If yes, see			IN IN		IN IN	21.00
	instructions.						
		•					
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	ALS ONLY (EXCE	PI CHILDRENS F	IOSPITALS)			-
22.00	Capital Related Cost Have assets been relifed for Medicare purpose	s? If yes see	instructions				22.00
	Have changes occurred in the Medicare depreci			sals made durin	a the cost		23.00
20.00	reporting period? If yes, see instructions.	attront expense	ado to apprais		.g 110 0001		20.00
24.00	Were new leases and/or amendments to existing	g Leases entere	ed into during	this cost repo	orting period?		24.00
	If yes, see instructions						
25.00	Have there been new capitalized leases entere instructions.	ed into during	the cost repor	rting period? I	f yes, see		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acqu	uired during th	ne cost renorti	na period? If	Ves see		26.00
20.00	instructions.	an ou dui ng ti		ng porrour ri	J00, 000		20.00
27.00	Has the provider's capitalization policy char	nged during the	e cost reportir	ng period?lf y	ves, submit		27.00
	copy.						
20 00	Interest Expense	c of crodit or	torod into dur	sing the cost r	oporting		28.00
20.00	Were new loans, mortgage agreements or letter period? If yes, see instructions.	S OF CIEULL EI		The cost i	eportring		20.00
29.00	Did the provider have a funded depreciation a	account and/or	bond funds (De	ebt Service Res	erve Fund)		29.00
	treated as a funded depreciation account? If	yes, see instr	ructions				
30.00	Has existing debt been replaced prior to its	scheduled matu	urity with new	debt? If yes,	see		30.00
31.00	instructions. Has debt been recalled before scheduled matur	aity without is	scuence of new	dobt2 If yoc	c		31.00
31.00	instructions.	ity without is	suance of new	debt? IT yes,	266		31.00
	Purchased Servi ces						
32.00	Have changes or new agreements occurred in pa	atient care ser	rvi ces furni she	ed through cont	ractual		32.00
	arrangements with suppliers of services? If						
33.00	If line 32 is yes, were the requirements of S	Sec. 2135.2 app	olied pertainir	ng to competiti	ve bidding? If		33.00
	no, see i nstructi ons. Provi der-Based Physi ci ans						-
34.00	Are services furnished at the provider facili	ty under an ar	rangement with	n provi der-base	ed physicians?		34.00
	If yes, see instructions.	,	5	F			
35.00	If line 34 is yes, were there new agreements			nts with the pr	ovi der-based		35.00
	physicians during the cost reporting period?	lfyes, see ir	nstructions.		N/ (b)		
					Y/N 1.00	Date 2.00	
-	Home Office Costs				1.00	2.00	
36.00	Were home office costs claimed on the cost re	eport?					36.00
37.00	If line 36 is yes, has a home office cost sta	atement been pr	repared by the	home office?			37.00
	If yes, see instructions.						
38.00	If line 36 is yes, was the fiscal year end of the provider? If yes, enter in column 2 the f						38.00
39 00	If line 36 is yes, did the provider render se						39.00
57.00	see instructions.			icitta: 11 yea,			57.00
40.00	If line 36 is yes, did the provider render se	ervices to the	home office?	lfyes, see			40.00
	instructions.						
			1	00	2	00	-
	Cost Report Preparer Contact Information		I I.	00	2.	00	
	Enter the first name, last name and the title	e/position	JAVI ER		CANETTI		41.00
	held by the cost report preparer in columns						
	respectively.						
42.00	Enter the employer/company name of the cost i	report	CAMPBELLWI LSON	I, LLP			42.00
43.00	preparer. Enter the telephone number and email address	of the cost	214-373-7077		JAVI ER. CANETTI		43.00
43.00	report preparer in columns 1 and 2, respectiv		214-3/3-7077		N. COM	SCAWFDLLLWI LOU	43.00
		· - · J ·	I			1	

		ARRIS CO PSYCH	HI ATRI			u of Form CMS-	
HOSPI T.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE		Provider CCN: 454076	Peri od: From 09/01/2014 To 08/31/2015	Worksheet S-2 Part II Date/Time Pre 1/28/2016 11:	epared:
		Part B					
		Date	1				
		4.00					
	PS&R Data		1				1
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	12/10/2015					16.00
17.00	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)						17.00
18.00	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 cost report? If yes, see instructions.						18. 0
19. 00	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.						19. 0
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:						20.0
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.						21.0
				3.00			
	Cost Report Preparer Contact Information		1	0.00	I		
	Enter the first name, last name and the title held by the cost report preparer in columns ' respectively.		MANAG	ER CONSULTI NG			41.0
42.00	Enter the employer/company name of the cost r preparer.	report					42.0
	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						43.0

	Financial Systems H TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	ARRIS CO PSYCH			CCN: 454076	Pe	ri od:	u of Form CMS- Worksheet S-		102 10
						Fr To	09/01/2014 08/31/2015	Part I Date/Time Pro 1/28/2016 11		
								I/P Days / O/I Visits / Trips		
	Component	Worksheet A Line Number	No. c	of Beds	Bed Days Available		CAH Hours	Title V	1	
		1.00	2	. 00	3.00		4.00	5.00	+	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30.00		250	91, 0	75	0.00		C	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider									2.00 3.00 4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF			050	04.0	7.5	0.00	(5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)			250	91, 0		0.00			7.00
8.00 9.00 10.00 11.00 12.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	31.00		0		0	0.00	(8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00 17.00 18.00	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER			250	91, 0	75	0. 00	(2	13.00 14.00 15.00 16.00 17.00 18.00
19.00 20.00 21.00 22.00 23.00 24.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	45. 00		0		0		(C	19.00 20.00 21.00 22.00 23.00 24.00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30. 00								24. 10 25. 00
26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	88. 00 89. 00		250 0		0		(5	26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01

PITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	F	eriod: rom 09/01/2014 o 08/31/2015		pare
	I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	(00	7.00	Patients	& Residents	Payrol I	
	6.00	7.00	8.00	9.00	10.00	1
0 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	3, 179	1, 473	81, 655			1.
Hospice days) (see instructions for col. 2						
for the portion of LDP room available beds)		0				
0 HMO and other (see instructions)	0	0				2
0 HMO I PF Subprovi der	0	0				
0 HMO IRF Subprovider 0 Hospital Adults & Peds. Swing Bed SNF	0	0	C			4
1 5	U	0	-			
0 Hospital Adults & Peds. Swing Bed NF	2 170	0	-			6
0 Total Adults and Peds. (exclude observation beds) (see instructions)	3, 179	1, 473	81, 655			7
0 INTENSIVE CARE UNIT	0	0	c			6
O CORONARY CARE UNIT	U	0				
DO BURN INTENSIVE CARE UNIT						10
00 SURGICAL INTENSIVE CARE UNIT						11
00 OTHER SPECIAL CARE (SPECIFY)						12
00 NURSERY						13
00 Total (see instructions)	3, 179	1, 473	81, 655	16.60	474.26	
00 CAH visits	3, 17,7	1, 475	01,000	10.00	474.20	15
00 SUBPROVIDER - IPF	Ű	0				10
00 SUBPROVIDER - IRF						17
00 SUBPROVI DER						18
00 SKILLED NURSING FACILITY						19
00 NURSING FACILITY		0	C	0.00	0.00	
00 OTHER LONG TERM CARE		0	, C	0.00	0.00	21
00 HOME HEALTH AGENCY						22
00 AMBULATORY SURGICAL CENTER (D. P.)						23
00 HOSPI CE						24
10 HOSPICE (non-distinct part)	0	0	C C			24
OO CMHC - CMHC	-	-	-			25
00 RURAL HEALTH CLINIC	0	0	C C	0.00	0.00	
25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00		
00 Total (sum of lines 14-26)		-		16.60		
00 Observation Bed Days		0	c			28
00 Ambul ance Trips	0	-	-			29
00 Employee discount days (see instruction)			C			30
00 Employee discount days - IRF			C			31
00 Labor & delivery days (see instructions)	0	0	0)		32
01 Total ancillary labor & delivery room	Ŭ	0	0)		32
outpatient days (see instructions)			Ĭ			~~
00 LTCH non-covered days	o					33

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 454076	Period: From 09/01/2014 To 08/31/2015	Worksheet S-3 Part I Date/Time Prep 1/28/2016 11:2	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Patients	
		11.00	12.00	13.00	14.00	15.00	1 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2		0	3	43 204	8, 818	1. 00
2 00	for the portion of LDP room available beds)				0		2 00
2.00	HMO and other (see instructions)				0 0		2.00
3.00	HMO I PF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNI T						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)	0. 00	0	3	43 204	8, 818	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER – IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY	0.00					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	HOSPICE						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
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00 30.00	Ambul ance Trips						29.00 30.00
30.00	Employee discount days (see instruction) Employee discount days - IRF						30.00
32.00 32.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room						32.00 32.01
JZ. UI	outpatient days (see instructions)						32.01
~~ ~~	LTCH non-covered days						33.00

lealth Financial Systems RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	<u>HARRES CO_PSYCHEA</u> DF_EXPENSES		CCN: 454076	Peri od:	u of Form CMS-: Worksheet A	2002 1
				From 09/01/2014 To 08/31/2015	Date/Time Pre	nared
				-	1/28/2016 11:	
Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	1 Reclassificati ons (See A-6)	Reclassified Trial Balance	
			+ cor. 2)	UIIS (See A-0)	(col. 3 +-	
					col. 4)	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
I. 00 00100 NEW CAP REL COSTS-BLDG & FIXT		0		0 24, 923	24, 923	1.0
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		0		0 0	0	
3.00 00300 OTHER CAPITAL RELATED COSTS		0		0 0	0	3.0
I. 00 00400 EMPLOYEE BENEFI TS DEPARTMENT	951, 105	9,086,911				
5. 00 00500 ADMINI STRATI VE & GENERAL 5. 00 00600 MAI NTENANCE & REPAI RS	3, 764, 268	2,042,308	5, 806, 57	76 -282, 342 0 0	5, 524, 234 0	1
7. 00 00700 OPERATION OF PLANT	1,054,969	1, 239, 538	2, 294, 50	-24, 923	-	
3. 00 00800 LAUNDRY & LINEN SERVICE	0	257, 464	257, 46	64 0	257, 464	8.0
9.00 00900 HOUSEKEEPING	0	482, 430			482, 430	
IO. 00 01000 DI ETARY I 1. 00 01100 CAFETERI A	0	1, 739, 788	1, 739, 78	38 0	1, 739, 788	1
2.00 01200 MAINTENANCE OF PERSONNEL	0	0			0	11.0
13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 657, 237	109, 463	1, 766, 70		1, 766, 700	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	
15. 00 01500 PHARMACY	0	0		0 0	0	
16.00 01600 MEDICAL RECORDS & LIBRARY	331, 613	31, 379	362, 99	92 0	362, 992	
17. 00 01700 SOCIAL SERVICE 19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0			0	
20. 00 02000 NURSI NG SCHOOL	0	0		0 0	0	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0		0 294, 573	294, 573	21.0
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0 941, 414		
23.00 02300 PARAMED ED PRGM	0	0		0 0	0	23.0
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	21, 086, 868	1, 863, 827	22, 950, 69	-1, 065, 230	21, 885, 465	30.0
31. 00 03100 I NTENSI VE CARE UNI T	21,000,000	1,003,027		0 0		1
15.00 04500 NURSING FACILITY	0	0		0 0		
ANCI LLARY SERVI CE COST CENTERS			1		-	
64. 00 05400 RADI OLOGY-DI AGNOSTI C 64. 01 05401 ANCI LLARY SERVI CES	0 45, 205	0 480, 637		0 0 12 0	0 525, 842	
66. 00 05600 RADI OI SOTOPE	45, 205	460, 037	525, 64	0 0	0 525, 842	
57. 00 05700 CT SCAN	0	0		0 0	0	
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.0
9.00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
0. 00 06000 LABORATORY 0. 01 06001 BLOOD LABORATORY	0	0		0 0	0	60. C
5. 00 06500 RESPIRATORY THERAPY	0	0		0 0	0	65.0
6.00 06600 PHYSI CAL THERAPY	0	0		0 0	0	
7. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
07.01 06701 THERAPY SERVICES	2, 468, 054	155, 392	2, 623, 44			
7. 02 03320 ELECTROSHOCK THERAPY 8. 00 06800 SPEECH PATHOLOGY	0	0		0 137, 934 0 0		
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	1
3.00 07300 DRUGS CHARGED TO PATIENTS	903, 591	794, 042	1, 697, 63	33 0	1, 697, 633	73.0
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	
75. 00 07500 ASC (NON-DI STI NCT PART) 76. 00 03020 PARTI AL HOSPI TALI ZATI ON	0	0			0	
OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	70.0
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 0
39.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.0
0.00 09000 CLINIC	0	0		0 0	0	
1.00 09100 EMERGENCY	0	0		0	0	
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS			1		L	92.0
18.00 SUBTOTALS (SUM OF LINES 1-117)	32, 262, 910	18, 283, 179	50, 546, 08	-81, 238	50, 464, 851	118.0
NONREI MBURSABLE COST CENTERS				0.,200]
90.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 0
91. 00 19100 RESEARCH	0	0		0 81, 238		
91.01 19101 PROBATE COURT 200.00 TOTAL (SUM OF LINES 118-199)	0 32, 262, 910	0 18, 283, 179	50, 546, 08	0 0 39 0		191.0
00.00 TOTAL (SUM OF LINES 118-199)	32, 202, 910	10, 203, 179	1 30, 340, 08	ע ויינ	JU, 540, 089	1200. U

CLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der	CCN: 454076	Peri od:	Worksheet A
					From 09/01/2014 To 08/31/2015	Date/Time Prepa 1/28/2016 11:28
	Cost Center Description	Adjustments	Net Expenses		· · ·	172072010 11.20
		(See A-8)	For Allocation			
	GENERAL SERVICE COST CENTERS	6.00	7.00			
00	00100 NEW CAP REL COSTS-BLDG & FIXT	132, 479	157, 402	1		
00	00200 NEW CAP REL COSTS-BEDG & TIXT	155, 828		1		
00	00300 OTHER CAPITAL RELATED COSTS	133, 020		1		
0	00400 EMPLOYEE BENEFITS DEPARTMENT	165, 887	-	1		
0	00500 ADMINI STRATI VE & GENERAL	1, 802, 092				
0	00600 MAI NTENANCE & REPAI RS	C		1		
0	00700 OPERATION OF PLANT	C	2, 269, 584			
00	00800 LAUNDRY & LINEN SERVICE	C	257, 464			
0	00900 HOUSEKEEPI NG	C				
	01000 DI ETARY	-7, 200		1		1
		C	-	1		1
	01200 MAINTENANCE OF PERSONNEL	0	-			1
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	-15 C		1		1
	01500 PHARMACY		-	1		1
	01600 MEDICAL RECORDS & LIBRARY	-31, 211	-	1		1
	01700 SOCIAL SERVICE	01,211		1		1
	01900 NONPHYSI CLAN ANESTHETI STS		-	1		1
	02000 NURSI NG SCHOOL	C		1		2
00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	C	294, 573			2
00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	C	941, 414			2
00	02300 PARAMED ED PRGM	C	0 0)		2
~ ~	INPATIENT ROUTINE SERVICE COST CENTERS	0. (05. 47.	10,100,001	1		
	03000 ADULTS & PEDIATRICS	-3, 695, 474		1		3
	03100 INTENSIVE CARE UNIT 04500 NURSING FACILITY			1		3
00	ANCI LLARY SERVICE COST CENTERS			1		4
00	05400 RADI OLOGY-DI AGNOSTI C	C				5
	05401 ANCI LLARY SERVI CES	C	525, 842			5
00	05600 RADI OI SOTOPE	C	0 0			5
	05700 CT SCAN	C	0			5
	05800 MAGNETIC RESONANCE I MAGING (MRI)	C	0			5
	05900 CARDI AC CATHETERI ZATI ON	C	0	1		5
				1		6
	06001 BLOOD LABORATORY			1		6
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY					6
	06700 OCCUPATI ONAL THERAPY		-			6
	06701 THERAPY SERVICES		-	1		6
	03320 ELECTROSHOCK THERAPY	-4	137, 930	1		6
	06800 SPEECH PATHOLOGY	C		1		6
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C		•		7
	07200 IMPL. DEV. CHARGED TO PATIENTS	C	۳ ۱			7
	07300 DRUGS CHARGED TO PATIENTS	C		1		7
	07400 RENAL DI ALYSI S	C		-		7
	07500 ASC (NON-DI STI NCT PART)	C	-	1		7
υU	03020 PARTIAL HOSPITALIZATION OUTPATIENT SERVICE COST CENTERS	C	0 0	1		7
00	08800 RURAL HEALTH CLINIC	C				
	08900 FEDERALLY QUALIFIED HEALTH CENTER		-	1		8
	09000 CLINIC		-	1		9
	09100 EMERGENCY	C	-	1		9
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					9
	SPECIAL PURPOSE COST CENTERS					
3. 00		-1, 477, 618	48, 987, 233			11
	NONREI MBURSABLE COST CENTERS		<u>, </u>			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	-	1		19
	19100 RESEARCH	C	81, 238			19
	19101 PROBATE COURT					19

	Financial Systems	Н	ARRIS CO PSYCHI			-	u of Form CMS	
RECLAS	SIFICATIONS			Provi der	CCN: 454076	Peri od:	Worksheet A-	-6
						From 09/01/2014 To 08/31/2015	Date/Time Pr 1/28/2016 11	repared: 1:28 am
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A - LEASE AND RENTALS							
. 00	NEW CAP REL COSTS-BLDG &	1.00	0	24, 923				1.0
	FIXT							
	0		0	24, 923				
	B - EMPLOYEE BENEFITS							
. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3 <u>0, 3</u> 47				1.0
	0		0	30, 347				
	C - INTERN AND RESIDENTS							
. 00	I&R SERVICES-OTHER PRGM	22.00	0	941, 414				1.0
	COSTS APPRVD	+	+_					
	0		0	941, 414				
	D - SALARY AND BENEFITS RECLA				1			_
. 00	ADULTS & PEDIATRICS		13 <u>3, 8</u> 69	11 <u>8, 1</u> 26				1.0
	0		133, 869	118, 126				_
	E - TIME STUDY ALLOCATION REC				L			_
. 00	I&R SERVICES-SALARY &	21.00	294, 573	0				1. (
	FRINGES APPRVD			_				
. 00	RESEARCH	<u> </u>	81, 238	0				2.0
			375, 811	0				_
~~	F - REFRACTORY DEPRESSION REC		10.05-1	00.077	1			
. 00	ELECTROSHOCK THERAPY	<u> </u>	48, 957	8 <u>8,977</u>				1.
	TOTALS		48, 957	88, 977				
00. OC	Grand Total: Increases		558, 637	1, 203, 787				500.

Heal th	Financial Systems	ł	HARRIS CO PSYCHI	ATRIC CENTER		In Lie	u of Form CM	S-2552-10
RECLASS	SIFICATIONS			Provi der	CCN: 454076	Period: From 09/01/2014 To 08/31/2015	Worksheet A Date/Time F	
						10 00/01/2010	1/28/2016 1	
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	-		
	6. 00	7.00	8.00	9.00	10.00			
	A - LEASE AND RENTALS							
1.00	OPERATION OF PLANT	7.00	0	2 <u>4, 9</u> 23	1	0		1.00
	0		0	24, 923				
	B - EMPLOYEE BENEFITS							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	3 <u>0, 3</u> 47		Q		1.00
	0		0	30, 347				
	C - INTERN AND RESIDENTS							
1.00	ADULTS & PEDIATRICS		0	<u> </u>		Q		1.00
	0		0	941, 414				
	D - SALARY AND BENEFITS RECLA	ASS TO CC 30						
1.00	ADMI NI STRATI VE & GENERAL	5.00	13 <u>3, 8</u> 69	<u>118, 1</u> 26		Q		1.00
	0		133, 869	118, 126				
	E - TIME STUDY ALLOCATION REC	CLASS						
1.00	ADULTS & PEDIATRICS	30.00	375, 811	0		0		1.00
2.00	L	0.00	0	0		Q		2.00
	0		375, 811	0				
	F - REFRACTORY DEPRESSION REC							
1.00	THERAPY_SERVICES	67.01	48, 957	<u> </u>		0		1.00
	TOTALS		48, 957	88, 977				
500.00	Grand Total: Decreases		558, 637	1, 203, 787				500.00

		ARRIS CO PSYCHI				eu of Form CMS-	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 454076	Period: From 09/01/201 To 08/31/201		pared:
				Acqui si ti on	S		
		Begi nni ng Bal ances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	BALANCES					
1.00	Land	0	0		0	0 0	1.00
2.00	Land Improvements	0	0		0	0 0	
3.00	Buildings and Fixtures	20, 745, 777	0		0	0 0	3.00
4.00	Building Improvements	6, 355, 126	2, 915, 104		0 2, 915, 10	4 0	4.00
5.00	Fixed Equipment	0	0		0	0 0	5.00
6.00	Movable Equipment	3, 696, 563	0		0	0 381, 324	6.00
7.00	HIT designated Assets	0	0		0	0 0	7.00
8.00	Subtotal (sum of lines 1-7)	30, 797, 466	2, 915, 104		0 2, 915, 10	4 381, 324	8.00
9.00	Reconciling Items	0	0		0	0 0	9.00
10.00	Total (line 8 minus line 9)	30, 797, 466	2, 915, 104		0 2, 915, 10	4 381, 324	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	BALANCES					
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	20, 745, 777	0				3.00
4.00	Building Improvements	9, 270, 230	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	3, 315, 239	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	33, 331, 246	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	33, 331, 246	0				10.00

Heal th	Financial Systems	HARRIS CO PSYCH	IATRIC CENTER		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 454076	Period: From 09/01/2014	Worksheet A-7 Part II	
					To 08/31/2015	Date/Time Pre	
						1/28/2016 11:	28 am
			SL	JMMARY OF CAF	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	•	
						instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2	-		
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	-				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

Heal th	Financial Systems	ARRIS CO PSYCH	II ATRI C CENTER		In Lie	u of Form CMS-2	2552-10
RECONCI	LIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 09/01/2014 Fo 08/31/2015	Worksheet A-7 Part III Date/Time Prep 1/28/2016 11:2	pared: 28 am
		COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPI TAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col.	Ratio (see instructions)	Insurance	
		1.00	2.00	<u>2)</u>	4,00	5, 00	
I	PART III - RECONCILIATION OF CAPITAL COSTS CE						
	NEW CAP REL COSTS-BLDG & FIXT	20, 745, 777	0	20, 745, 77	7 0. 622412	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	12, 585, 469		12, 585, 469		0	2.00
3.00	Total (sum of lines 1-2)	33, 331, 246	0	33, 331, 240	1. 000000	0	3.00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPI TAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capital-Relate d Costs	cols. 5 through 7)			
		6.00	7.00	8.00	9.00	10.00	
F	PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS	•				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	(0 132, 479	24, 923	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	(0 155, 828		2.00
3.00	Total (sum of lines 1-2)	0	0	(288, 307	24, 923	3.00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see instructions)	through 14)	
		11.00	12.00	13.00	14,00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
	NEW CAP REL COSTS-BLDG & FIXT	0	0	(0 0	157, 402	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	155, 828	2.00
3.00	Total (sum of lines 1-2)	0	0	(0 0	313, 230	3.00
			•				

	Financial Systems MENTS TO EXPENSES		ARRIS CU PSICE		Peri od:	u of Form CMS-2 Worksheet A-8	
					From 09/01/2014 To 08/31/2015	Date/Time Pre	pared:
				Expense Classification or		1/28/2016 11:	<u>28 am</u>
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	1.00		NEW CAP REL COSTS-BLDG & FLXT	1.00	0	1.00
2.00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		C	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	2) Investment income - other		C		0.00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time		C		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		C		0.00	0	5.00
	expenses (chapter 8)		-			-	
6.00	Rental of provider space by suppliers (chapter 8)		C		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		C		0.00	0	7.00
3. 00	Television and radio service		C		0.00	0	8. 00
9.00 10.00	(chapter 21) Parking Lot (chapter 21) Provider-based physician	A-8-2	C -3, 583, 417		0.00	0 0	
1.00	adjustment Sale of scrap, waste, etc.		C		0.00	0	11.00
2.00	(chapter 23) Related organization	A-8-1	-110, 835			0	12.00
	transactions (chapter 10)				0.00		
3.00 4.00	Laundry and linen service Cafeteria-employees and guests	В	C -7, 200	DI ETARY	0.00 10.00	0	
5.00	Rental of quarters to employee and others		C		0.00	0	15.00
6. 00	Sale of medical and surgical supplies to other than		C		0.00	0	16.00
7.00	patients Sale of drugs to other than		C		0.00	0	17.00
8.00	patients Sale of medical records and	В	-31, 123	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
9.00	abstracts Nursing school (tuition, fees,		C		0.00	0	19.00
	books, etc.)		-				
	Vending machines Income from imposition of interest, finance or penalty	В	-11, 000 C	ADMI NI STRATI VE & GENERAL	5.00 0.00	0 0	20.00 21.00
22.00	charges (chapter 21) Interest expense on Medicare		C		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT		C	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-MVBLE	2.00	0	27.00
8. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		C	EQUI P NONPHYSI CI AN ANESTHETI STS	19.00		28.00
9.00 0.00	Physicians' assistant Adjustment for occupational	A-8-3	C	OCCUPATI ONAL THERAPY	0.00 67.00	0	29.00 30.00
.5. 50	therapy costs in excess of	A 0-0	C	COURT ONAL THENALT	07.00		30.00
80. 99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30. 99
1.00	instructions) Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68.00		31.00
1.00	pathology costs in excess of	A-0-3	L.		00.00		
2.00	limitation (chapter 14) CAH HIT Adjustment for		C		0.00	0	32.00
	Depreciation and Interest						

Health Financial Systems	ŀ	ARRIS CO PSYCH	II ATRI C CENTER	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 454076	Peri od:	Worksheet A-8	
				From 09/01/2014		
				To 08/31/2015	Date/Time Prep 1/28/2016 11:	
			Expense Classification o	n Worksheet A	1/20/2010 11.2	20 811
			To/From Which the Amount is			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.00 MISC INCOME	В	-11, 595	ADMI NI STRATI VE & GENERAL	5.00	0	33.00
33.01 NON ALLOWABLE EXPENSES	A	-67, 980	ADMI NI STRATI VE & GENERAL	5.00	0	33.01
33.02 NON ALLOWABLE EXPENSES	A	-15	NURSING ADMINISTRATION	13.00	0	33.02
33.03 NON ALLOWABLE EXPENSES	A	-88	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04 NON ALLOWABLE EXPENSES	A	-30	ADULTS & PEDIATRICS	30.00	0	33.04
33.05 NON ALLOWABLE EXPENSES	A	- 4	ELECTROSHOCK THERAPY	67.02	0	33.05
33.06 MEDICAL FRINGE BENEFITS	A	-26, 139	ADMI NI STRATI VE & GENERAL	5.00	0	33.06
33.07 NURSE PRACTITIONER	A	-84, 627	ADULTS & PEDIATRICS	30.00	0	33.07
33.08 ADD ON TO REPORT RELATED PARTY	΄ Α	2, 515, 431	ADMINISTRATIVE & GENERAL	5.00	0	33.08
COST						
33.09 ON-CALL FEES	A	-27, 400	ADULTS & PEDIATRICS	30.00	0	33.09
33.10 PHYSICIANS BILLING COST	A	-31, 596	ADMI NI STRATI VE & GENERAL	5.00	0	33. 10
REMOVAL						
50.00 TOTAL (sum of lines 1 thru 49)		-1, 477, 618				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

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

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

Heal th	Financial Systems	HARRIS CO PSYC	HIATRIC CENTER	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 454076	Period:	Worksheet A-8	8-1
OFFICE				From 09/01/2014 To 08/31/2015		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HCPC BUILDING DEPRECIATION	132, 479	0	1.00
2.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	HCPC EQUIPMENT DEPRECIATION	155, 828	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HCPC RELATED BENEFIT COST	165, 887	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HCPC RELATED A&G COST	1, 950, 401	2, 515, 430	4.00
5.00	TOTALS (sum of lines 1-4).			2, 404, 595	2, 515, 430	5.00
	Transfer column 6, line 5 to				,	
	Worksheet A-8, column 2,					
	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.

nas not	Deen posted to worksheet A,	corumns ranu/or z, the amount	it allowable si		or this part.	
				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	
	R INTERPRIATIONSHIP TO PELAT	ED OPCANIZATION(S) AND/OP HO				

B. INTERRELATIONSHIP TO RELATED 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	В	UT HEALTH CNTR	50.00	UT HEALTH CTR	50.00	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					100.00
	non-financial) specify:					1

(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.

Health Financial Systems HARRIS CO PSYCHIATE	RIC CENTER	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 454076	Period: From 09/01/2014	Worksheet A-8-1
OFFICE COSTS			Date/Time Prepared:

			1/28/2016 11	
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	132, 479	9		1.00
2.00	155, 828	9		2.00
3.00	165, 887	0		3.00
4.00	-565, 029	0		4.00
5.00	-110, 835			5.00

* 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

nas	not been posted to worksheet A,	cordinars i and/or 2, the amount arrowable should be thurcated in cordinar 4 of this part.	
	Rel ated Organi zati on(s)		
	and/or Home Office		
	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

i ei iibui	Sement under title AVIII.	
6.00	HEALTH/EDUCATI 0	6.00
7.00 8.00		7.00
		8.00
9. 00 10. 00		9.00
10.00		10.00
100.00		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.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

Director, officer, administrator, or key person of related organization or relative of such person has financial interest in F. provi der.

Health Financial Systems	

HARRIS CO PSYCHIATRIC CENTER

In Lieu of Form CMS-2552-10

	Financial Syste		HARRIS CU PSYC				eu or Form CMS-	
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provi der	F	Period: From 09/01/2014 Fo 08/31/2015	5 Date/Time Pre	epared:
							1/28/2016 11:	<u>28 am</u>
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identi fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		AGGREGATE-ADMI NI STRATI VE &	0.00					1.00
1.00	5.00	GENERAL			0	170,000	0	1.00
2 00	20.00		2 0 2 7 4	2 502 417	254 244	17/ 000	F 700	2.00
2.00		AGGREGATE-ADULTS &	3, 837, 761	3, 583, 417	254, 344	176, 800	5, 722	2.00
		PEDI ATRI CS	-		_		-	
3.00	0.00		0		-	0	0	3.00
4.00	0.00		0	C	0	0	0	4.00
5.00	0.00		0	C	0	0	0	5.00
6.00	0.00		0	c c	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00				0	0	0	8.00
9.00	0.00				0		0	9.00
			0		0	0	Ŭ	
10.00	0.00		0		0	0	0	
200.00			3, 837, 761				5, 722	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identi fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		AGGREGATE - ADMI NI STRATI VE &	0					1.00
1.00		GENERAL	l °	Ŭ	0	0	j ő	1.00
2.00		AGGREGATE-ADULTS &	486, 370	24, 319	0	0	0	2.00
2.00			400, 370	24, 319	0	0	0	2.00
		PEDI ATRI CS						
3.00	0.00		0		-	0	-	3.00
4.00	0.00		0	C	0	0	0	4.00
5.00	0.00		0	C	0	0	0	5.00
6.00	0.00		0	C	0	0	0	6.00
7.00	0.00		0	l c	0	0	0	7.00
8.00	0.00		0		0	0	0	8.00
9.00	0.00		0		0	0	-	9.00
					0			
10.00	0.00		0		0	-	-	
200.00			486, 370			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMI NI STRATI VE &	0	C	0	0		1.00
		GENERAL			1			
2.00	30.00	AGGREGATE-ADULTS &	0	486, 370	0	3, 583, 417		2.00
2.00		PEDI ATRI CS			l i			2.00
3.00	0.00		0	c	0	о		3.00
			-	-	-			
4.00	0.00		0	C	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	-	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0		0	0		9.00
10.00	0.00				Ű.	0		10.00
200.00	0.00		0		° °	-		200.00
200.00	I		1 0	400,370	u 0	3, 303, 417	I	200.00

	ncial Systems ATION - GENERAL SERVICE COSTS	HARRIS CO PSYCHI			eriod: rom 09/01/2014	u of Form CMS-: Worksheet B Part I Date/Time Pre	
					o 08/31/2015	1/28/2016 11:	
			CAPI TAL REL	LATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		(from Wkst A col. 7)			DEFARTMENT		
		0	1.00	2.00	4.00	4A	
	RAL SERVICE COST CENTERS	157, 402	157, 402				1.00
	O NEW CAP REL COSTS-DEDG & TTAT	155, 828	137, 402	155, 828			2.00
	O EMPLOYEE BENEFITS DEPARTMENT	10, 234, 250	0	0	10, 234, 250		4.00
	O ADMINI STRATI VE & GENERAL	7, 326, 326	26, 304	26, 041	1, 186, 596		5.00
	0 MAINTENANCE & REPAIRS 0 OPERATION OF PLANT	0 2, 269, 584	0 9, 012	0 8, 922	0	0 2, 632, 335	
	O LAUNDRY & LINEN SERVICE	2, 209, 584	9, 012 1, 055			2, 032, 335 259, 563	
	O HOUSEKEEPI NG	482, 430	547	541		483, 518	
10.00 01000	0 DI ETARY	1, 732, 588	8, 795	8, 707	0	1, 750, 090	10.00
	O CAFETERIA	0	0	0	-	0	
	O MAINTENANCE OF PERSONNEL	1 7(((05	0	0	-	0 2, 312, 691	
	O NURSI NG ADMI NI STRATI ON O CENTRAL SERVI CES & SUPPLY	1, 766, 685	2, 180 0	2, 158 0	541, 668 0	2, 312, 691	
	O PHARMACY	0	0	0	0	0	
	0 MEDICAL RECORDS & LIBRARY	331, 781	1, 678	1, 661	108, 388	443, 508	16.00
	O SOCIAL SERVICE	0	0	0	-	0	
	O NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	
	0 NURSI NG SCHOOL 0 I &R SERVI CES-SALARY & FRI NGES APPRVD	294, 573	0	0	96, 281	0 390, 854	
	0 I &R SERVICES-OTHER PRGM COSTS APPRVD	941, 414	823			943, 052	
	O PARAMED ED PRGM	0	0	0		0	
	TIENT ROUTINE SERVICE COST CENTERS						
	O ADULTS & PEDIATRICS	18, 189, 991	88, 108				
	O INTENSIVE CARE UNIT O NURSING FACILITY	0	0				
	LLARY SERVICE COST CENTERS	0	0	0	0	0	45.00
54.00 05400	0 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
	1 ANCI LLARY SERVI CES	525, 842	262	259			
	O RADI OI SOTOPE O CT SCAN	0	0	0	-	0	
	O MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	-	0	1
	O CARDI AC CATHETERI ZATI ON	0	0	0	-	0	1
	0 LABORATORY	0	0	0	0	0	60.00
	1 BLOOD LABORATORY	0	0	0	0	0	
	0 RESPI RATORY THERAPY 0 PHYSI CAL THERAPY	0	0	0	0	0	
	0 OCCUPATIONAL THERAPY	0	0	0	0	0	
	1 THERAPY SERVICES	2, 485, 512	10, 158		-		
	0 ELECTROSHOCK THERAPY	137, 930	1, 603		16, 002	157, 122	
	0 SPEECH PATHOLOGY	0	0	0	0	0	
	O MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
	0 I MPL. DEV. CHARGED TO PATI ENTS 0 DRUGS CHARGED TO PATI ENTS	1, 697, 633	1, 237	1, 225	0 295, 339	0 1, 995, 434	
	O RENAL DIALYSIS	0	0	0	0	0	1
	O ASC (NON-DISTINCT PART)	0	0	0	0	0	
/5.00 0/500		0	0	0	0	0	76.00
76.00 03020	O PARTIAL HOSPITALIZATION	0					
76.00 03020 0UTP/	ATIENT SERVICE COST CENTERS				0	0	
76.00 03020 0UTPA 38.00 08800	ATIENT SERVICE COST CENTERS O RURAL HEALTH CLINIC	0	0			0	
76.00 03020 0UTPA 08800 38.00 08800 39.00 08900	ATI ENT SERVICE COST CENTERS O RURAL HEALTH CLINIC O FEDERALLY QUALIFIED HEALTH CENTER		0 0 0	0 0		0	89.00
76.00 03020 0UTP/ 0UTP/ 38.00 08800 39.00 08900 90.00 09000 91.00 09100	ATI ENT SERVICE COST CENTERS O RURAL HEALTH CLINIC O FEDERALLY QUALIFIED HEALTH CENTER O CLINIC O EMERGENCY	0					89. 00 90. 00
76.00 03020 OUTP/ 0UTP/ 38.00 08800 39.00 08900 70.00 09000 71.00 09100 92.00 09200	ATIENT SERVICE COST CENTERS ORURAL HEALTH CLINIC OFEDERALLY QUALIFIED HEALTH CENTER OCLINIC OEMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	0				0	89.00 90.00 91.00
76.00 03020 0UTP/ 0UTP/ 38.00 08800 39.00 08900 00.00 09000 01.00 09100 02.00 09200 SPECI SPECI	ATI ENT SERVICE COST CENTERS O RURAL HEALTH CLINIC O FEDERALLY QUALIFIED HEALTH CENTER O CLINIC O EMERGENCY O OBSERVATION BEDS (NON-DISTINCT PART) I AL PURPOSE COST CENTERS		0 0 0	0 0 0	0 0	0 0 0 0	89.00 90.00 91.00 92.00
76.00 03020 0UTP/ 0UTP/ 38.00 08800 39.00 08900 20.00 09000 21.00 09100 22.00 09200 SPECI 118.00	ATI ENT SERVICE COST CENTERS O RURAL HEALTH CLINIC O FEDERALLY QUALIFIED HEALTH CENTER O CLINIC O EMERGENCY O OBSERVATION BEDS (NON-DISTINCT PART) I AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	0		0 0	0 0	0 0 0 0	89.00 90.00 91.00 92.00
76.00 03020 OUTP/ 0UTP/ 38.00 08800 39.00 08900 90.00 09000 91.00 09100 92.00 09200 SPECI 118.00	ATI ENT SERVICE COST CENTERS O RURAL HEALTH CLINIC O FEDERALLY QUALIFIED HEALTH CENTER O CLINIC O EMERGENCY O OBSERVATION BEDS (NON-DISTINCT PART) IAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) EI MBURSABLE COST CENTERS		0 0 0 151, 762	00000	0 0 0 10, 207, 697	0 0 0 48, 949, 456	89.00 90.00 91.00 92.00
76.00 03020 OUTP/ 0UTP/ 38.00 08800 39.00 08900 90.00 09000 91.00 09100 92.00 09200 SPECI 118.00	ATI ENT SERVICE COST CENTERS O RURAL HEALTH CLINIC O FEDERALLY QUALIFIED HEALTH CENTER O CLINIC O EMERGENCY O OBSERVATION BEDS (NON-DISTINCT PART) IAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) EI MBURSABLE COST CENTERS O GIFT, FLOWER, COFFEE SHOP & CANTEEN	48, 987, 233	0 0 0	0 0 0 150, 244 519	0 0 0 10, 207, 697	0 0 0 48, 949, 456 1, 043	89.00 90.00 91.00 92.00 118.00
76.00 03020 OUTP/ 0017P/ 38.00 08800 39.00 08900 90.00 09000 91.00 09100 92.00 09200 SPECI 118.00 1990.01 19000 191.00 19100	ATI ENT SERVICE COST CENTERS O RURAL HEALTH CLINIC O FEDERALLY QUALIFIED HEALTH CENTER O CLINIC O EMERGENCY O OBSERVATION BEDS (NON-DISTINCT PART) I AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) EI MBURSABLE COST CENTERS O GIFT, FLOWER, COFFEE SHOP & CANTEEN O RESEARCH 1 PROBATE COURT	48, 987, 233	0 0 0 151, 762 524	0 0 150, 244 519 734	0 0 10, 207, 697 0 26, 553	0 0 0 48, 949, 456 48, 949, 456 1, 043 109, 266 8, 706	89.00 90.00 91.00 92.00 118.00 190.00 191.00
76.00 03020 0UTP/ 0UTP/ 88.00 08800 89.00 08900 90.00 09000 91.00 09100 92.00 09200 118.00 NONRE 190.00 19000 191.00 19000	ATI ENT SERVICE COST CENTERS O RURAL HEALTH CLINIC O FEDERALLY QUALIFIED HEALTH CENTER O CLINIC O EMERGENCY O OBSERVATION BEDS (NON-DISTINCT PART) IAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) EIMBURSABLE COST CENTERS O GIFT, FLOWER, COFFEE SHOP & CANTEEN O RESEARCH	48, 987, 233	0 0 0 151, 762 524 741	0 0 150, 244 519 734	0 0 10, 207, 697 26, 553 0	0 0 0 48, 949, 456 1, 043 109, 266 8, 706 0	89. 00 90. 00 91. 00 92. 00 118. 00

Heal th	Financial Systems	HARRIS CO PSYCH	II ATRI C CENTER		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	F	eriod: rom 09/01/2014 o 08/31/2015	Worksheet B Part I Date/Time Pre 1/28/2016 11:	pared: 28 am
	Cost Center Description		MAINTENANCE &		LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL 5.00	REPAIRS 6.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	
	GENERAL SERVICE COST CENTERS						
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 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	8, 565, 267					5.00 6.00
7.00	00700 OPERATI ON OF PLANT	556, 663		3, 188, 998			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	54, 890		27, 558			8.00
9.00	00900 HOUSEKEEPI NG	102, 250		14, 277	0	600, 045	9.00
10.00	01000 DI ETARY	370, 093	0	229, 730	0	43, 801	10.00
11.00	01100 CAFETERI A	C	0	0	0	0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	489, 067	0	56, 941	0	10, 857	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY		0		0	0	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	93, 789		43, 827	0	8, 356	
17.00	01700 SOCIAL SERVICE	C	Ő	0	0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	C	0	0	0	0	19.00
20.00	02000 NURSI NG SCHOOL	C	0	0	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	82, 654		0	0	0	21.00
22.00	02200 I & R SERVICES-OTHER PRGM COSTS APPRVD	199, 428		21, 498	0	4, 099	
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	C	0	0	0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	5, 324, 531	0	2, 301, 481	342, 011	438, 804	30.00
31.00	03100 I NTENSI VE CARE UNI T	3, 324, 331	0	2, 301, 401	0	430,004	31.00
45.00	04500 NURSING FACILITY	C		0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS	- -		•			
54.00	05400 RADI OLOGY-DI AGNOSTI C	C		0	0	0	54.00
54.01	05401 ANCI LLARY SERVI CES	114, 435	0	6, 834	0	1, 303	54.01
56.00	05600 RADI OI SOTOPE	C	0	0	0	0	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON		0		0	0	59.00
60.00	06000 LABORATORY		0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	C	0	0	0	0	60.01
65.00	06500 RESPI RATORY THERAPY	C	0	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	C	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01 67.02	06701 THERAPY SERVICES	697, 095 33, 227	0	265, 339	0	50, 590 7, 982	
67.02 68.00	03320 ELECTROSHOCK THERAPY 06800 SPEECH PATHOLOGY	33, 227	0	41, 862	0	7,982	67.02 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	421, 976	0	32, 317	0	6, 162	73.00
	07400 RENAL DIALYSIS	C	0	0	0	0	•
	07500 ASC (NON-DISTINCT PART)	C	0	0	0	0	
76.00	03020 PARTI AL HOSPI TALI ZATI ON	C	0	0	0	0	76.00
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC			0	0	0	
88.00 89.00	08800 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	88.00 89.00
90.00	09000 CLINIC				0	0	90.00
91.00	09100 EMERGENCY		0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		8, 540, 098	0	3, 041, 664	342, 011	571, 954	118.00
100 0	NONREI MBURSABLE COST CENTERS		-	40.45	-	0.443	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	221		13, 696			190.00
	19100 RESEARCH 19101 PROBATE COURT	23, 107		19, 368 114, 270		3, 693 21, 787	191.00 191.01
200.00		1,041		114,270	0	21,707	200.00
201.00		C	0	0	0	0	201.00
202.00		8, 565, 267	0	3, 188, 998	342, 011	600, 045	

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	HARRIS CO PSYCHI		CCN: 454076		i od:	u of Form CMS- Worksheet B	2552-10
					Fro To	09/01/2014 08/31/2015	Part I Date/Time Pre 1/28/2016 11:	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE (PERSONNEL	-	NURSI NG DMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
		10.00	11.00	12.00		13.00	14.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT							1.00
2.00	00200 NEW CAP REL COSTS-DEDG & TTXT							2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT							4.00
5.00	00500 ADMI NI STRATI VE & GENERAL							5.00
6.00	00600 MAINTENANCE & REPAIRS							6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE							7.00
9.00	00900 HOUSEKEEPING							9.00
10.00	01000 DI ETARY	2, 393, 714						10.00
11.00	01100 CAFETERI A	0	C					11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0			12.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	ĺ		0	2, 869, 556	0	13.00
15.00	01500 PHARMACY	0	(0	0	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	C	þ	0	0	0	
17.00	01700 SOCIAL SERVICE	0	C		0	0	0	
	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0	0	0	
20.00 21.00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0			0	0	0	
21.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0	0	0	
23.00	02300 PARAMED ED PRGM	0	C		0	0	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS			.1	-			
30.00	03000 ADULTS & PEDIATRICS	2, 363, 490	0		0	2, 869, 556	0	1
31.00 45.00	03100 I NTENSI VE CARE UNI T 04500 NURSI NG FACI LI TY	0	0		0 0	0 0	0	1
10.00	ANCI LLARY SERVICE COST CENTERS			<u> </u>				10.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	С		0	0	0	1
54.01	05401 ANCI LLARY SERVI CES	0	C)	0	0	0	
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0	(0	0	0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	(0	0	0	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C		0	0	0	
60.00	06000 LABORATORY	0	C		0	0	0	
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	0	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0			0	0	0	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	
67.01	06701 THERAPY SERVICES	0	C		0	0	0	
67.02	03320 ELECTROSHOCK THERAPY	0	C		0	0	0	
68.00	06800 SPEECH PATHOLOGY	0	(0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0		õ	0	0	1 . 2. 00
	07400 RENAL DI ALYSI S	0	C		0	0	0	
	07500 ASC (NON-DI STI NCT PART)	0	C		0	0	0	
/6.00	03020 PARTIAL HOSPITALIZATION OUTPATIENT SERVICE COST CENTERS	0			0	0	0	76.00
88.00	08800 RURAL HEALTH CLINIC	0	C		0	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0	0	0	
	09000 CLINIC	0	C		0	0	0	
	09100 EMERGENCY	0	C)	0	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS			I				92.00
118.00		2, 363, 490			0	2, 869, 556	0	118.00
	NONREI MBURSABLE COST CENTERS				-]
		30, 224	()	0	0	0	190.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	30, 224	-					
190. 00 191. 00	19100 RESEARCH	0	C		0	0		191.00
190.00 191.00 191.01	19100 RESEARCH 19101 PROBATE COURT	0 0	C		0 0	0 0		191.01
190. 00 191. 00	19100 RESEARCH 19101 PROBATE COURT Cross Foot Adjustments	0	c c c		0 0	0	0	

		HARRIS CO PSYCHI		CCN- 454074		workshoot R	2552-10
COST	ALLOCATION - GENERAL SERVICE COSTS		Provi der	1	Period: From 09/01/2014 To 08/31/2015		pared: 28 am
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CI	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT			1		1	1 1 00
2.00	00200 NEW CAP REL COSTS-BEDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00							10.00
11.00 12.00	01100 CAFETERIA						11.00 12.00
12.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY	0					15.00
	01600 MEDICAL RECORDS & LIBRARY	0	589, 480				16.00
17.00	01700 SOCIAL SERVICE	0	C		C		17.00
	01900 NONPHYSICIAN ANESTHETISTS	0	C		0 0		19.00
20.00	02000 NURSI NG SCHOOL	0	C		2	0	20.00
21.00	02100 I & R SERVICES-SALARY & FRINGES APPRVD	0	C				21.00
22.00 23.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	C				22.00 23.00
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	C	<u>/</u>	J		23.00
30.00	03000 ADULTS & PEDIATRICS	0	531, 878	3 (0 0	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	C		0 0		31.00
45.00	04500 NURSING FACILITY	0	C) (0 0	0	45.00
	ANCI LLARY SERVI CE COST CENTERS	· · · · · ·		.		-	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0		
54.01	05401 ANCI LLARY SERVI CES	0	4, 555		0		54.01
56.00 57.00	05600 RADI 0I SOTOPE 05700 CT SCAN	0	C			0	56.00 57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0				0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60.00	06000 LABORATORY	0	C		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	C		0 0	0	60.01
65.00	06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	C	1	0 0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	01 (15		0	0	67.00
67.01 67.02	06701 THERAPY SERVICES 03320 ELECTROSHOCK THERAPY	0	21,645			0	67.01 67.02
68.00	06800 SPEECH PATHOLOGY	0	1, 128 C			0	68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C				
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	30, 274	. (0 0	0	
	07400 RENAL DIALYSIS	0	C		0 0	0	
	07500 ASC (NON-DISTINCT PART)	0	C		0 0	0	
76.00	03020 PARTIAL HOSPITALIZATION	0	C) ()	0 0	0	76.00
88 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0			0 10	0	88.00
	08800 FEDERALLY QUALIFIED HEALTH CENTER	0	C C			0	
	09000 CLINIC	0	C C			0	
	09100 EMERGENCY	0	C		o o	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS			1	1		
118.00		0	589, 480) (0 0	0	118.00
100 5	NONREI MBURSABLE COST CENTERS			J	-	-	100 5
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C				190.00
	19100 RESEARCH 19101 PROBATE COURT	0					191. 00 191. 01
200.00		0	Ĺ	′			200.00
		1 1		1	0		
200.00	Negative Cost Centers		ſ			0	201.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	HARRIS CO PSYCH		CCN: 454076	Peri od:	u of Form CMS-2 Worksheet B	2002-10
					From 09/01/2014 To 08/31/2015	Part I Date/Time Pre	
		I NTERNS &	RESI DENTS			1/28/2016 11:	20 411
	Cost Center Description	SERVI CES-SALAR Y&FRI NGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	r	21.00	22.00	23.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS						1 00
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
	01000 DI ETARY 01100 CAFETERI A						10.00 11.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
	01600 MEDI CAL RECORDS & LI BRARY						16.00
	01700 SOCIAL SERVICE						17.00
	01900 NONPHYSI CLAN ANESTHETI STS						19.00
	02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRVD	473, 508					20.00 21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	475,500	1, 168, 077				22.00
	02300 PARAMED ED PRGM		1, 100, 077		0		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS				-1		
	03000 ADULTS & PEDIATRICS	473, 508	1, 168, 077		0 40, 991, 811	-1, 641, 585	30.00
	03100 I NTENSI VE CARE UNI T	0	0		0 0	0	31.00
45.00	04500 NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	0	45.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
	05401 ANCI LLARY SERVICES	0	0		0 668, 265	0	54.01
	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00	05700 CT SCAN	0	0		0 0	0	57.OC
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58. OC
	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	0		0 0	0	60. 00 60. 01
	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
	06600 PHYSI CAL THERAPY	0	0		0 0	0	66. OC
	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
	06701 THERAPY SERVICES	0	0		0 4, 331, 078	0	67.01
	03320 ELECTROSHOCK THERAPY	0	0		0 241, 321	0	67.02
	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 486, 163	0	73.00
	07400 RENAL DIALYSIS	0	0		0 0	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75. OC
76.00	03020 PARTI AL HOSPI TALI ZATI ON	0	0		0 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS	-	-			-	
	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00 89.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	90.00
	09100 EMERGENCY	0	n 0		0 0	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	473, 508	1, 168, 077		0 48, 718, 638	-1, 641, 585	118.00
	NONREI MBURSABLE COST CENTERS	1			_1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 47, 795		190.00
	19100 RESEARCH	0	0		0 155, 434		191.00
	10101 PPOPATE COUPT	^	<u>^</u>				
191.01	19101 PROBATE COURT Cross Foot Adjustments	0	0		0 146, 604		191.01 200.00
	Cross Foot Adjustments	0	0 0 0		0 146, 604 0 0 0 0	0	200. 00 201. 00

CGS1 ALLOCATION - GENERAL SERVICE CGS1S Provider CS4 44407 Period Monthead Period Monthead CGS1 Contert Description Total 20.00 10.00 <t< th=""><th>Health Financial Systems</th><th>I</th><th>HARRIS CO PSYCHIAT</th><th>TRIC CENTER</th><th>In Lieu of Form CM</th><th>IS-2552-10</th></t<>	Health Financial Systems	I	HARRIS CO PSYCHIAT	TRIC CENTER	In Lieu of Form CM	IS-2552-10
To Bits of the second part of an analysis of the second part of the	COST ALLOCATION - GENERAL	SERVICE COSTS		Provider CCN: 454076		В
Cost Center Description Total 70.00 70:00 (MS) CAP CONTRESS 70:00 (MS) CAP CONTRESS (MS)					To 08/31/2015 Date/Time	Prepared:
DENERAL SERVICE COST CENTERS 1.00 1.00 DDIOG NUP CAS FUNCE COST CENTERS 1.00 1.00 DDIOG NUP CAS FUNCE COST CENTERS 1.00 0.00 DDIOG NUP CAS FUNCE COST CENTERS 4.00 0.00 DDIOG NUP CENTERS SERVICE 5.00 0.00 DIIOG NUP CAST CONSTRATION 11.00 1.00 DIIOG NUP CAST CONSTRATION 13.00 1.00 DIIOG NUP CAST CONSTRATION 13.00 1.00 DIIOG NUP CAST CONSTRATION 14.00 1.00 DIIOG NUP CONSTRATION SERVICE 21.00 2.00 DIIOG NUP CONSTRATION SERVICE STEMPHY 14.00	Cost Center D)escription	Total		1/28/2016	<u>11:28 am</u>
1.00 00100 NEW CAP REL COSTS-BUDE & FLXT 1.00 2.00 00200 NEW CAP REL COSTS-BUDE & FLXT 4.00 4.00 D0200 NEW CAP REL COSTS-BUDE & FLXT 4.00 4.00 D0200 NEW CAP REL COSTS-BUDE & FLXT 4.00 4.00 D0200 NEW CAP REL COSTS-BUDE & FLXT 5.00 5.00 D0200 NEW CAP REL COSTS-BUDE & FLXT 7.00 5.00 D0200 NEW CAP REL COSTS-BUDE & FLXT 7.00 5.00 D0200 NEW CAP REL COSTS-BUDE & FLXT 7.00 5.00 D0200 NEW CAP REL COSTS-BUDE & FLXT 7.00 5.00 D0200 NEW CAP REL COSTS-BUDE & FLXT 7.00 5.00 D0200 NEW CAP REL COSTS-BUDE & FLXT 7.00 5.00 D0200 NEW CAP REL COSTS-BUDE & FLXT 7.00 5.00 D1200 NEW NEW CAP REL FLXTS 18.00 5.00 D1200 NEW SIG CAP REVENTER TSTS 19.00 5.00 D1200 NEW SIG CAP REVENTER TSTS 7.00 5.00 D1200 NEW SIG CAP REVENTER TSTS	cost center b	escription				
2.00 D0200 NEW CAP REL C0515 A 0						
4.00 004000 FUNCTION 4.00 5.00 005000 ADMINISTRATU PARA 6.00 6.00 000000 ADMINISTRATU PARA 6.00 6.00 000000 ADMINISTRATU PARA 6.00 6.00 000000 ADMINISTRATU PARA 8.00 6.00 000000 ADMINISTRATU PARA 8.00 6.00 000000 ADMINISTRATU PARA 10.00 6.00 000000 ADMINISTRATU PARA 11.00 11.00 01000 CAFETERIA 11.00 12.00 01000 MERIAN CARANANINISTRATU PARA 11.00 13.00 01000 MERIAN CARANANINISTRATU PARA 11.00 14.00 01000 MERIAN CARANANINISTRATU PARA 11.00 15.00 01000 MERIAN CARANANINISTRATU PARA 12.00 16.00 01000 MERIAN CARANANINISTRATU PARA 12.00 17.00 01000 MERIAN CARANANINISTRATU PARA 12.00 10.00 01000 MERIAN CARANANINISTRATU PARA 12.00 1						
5.00 DOSOD AVMINISTRATULE & CENTRAL. 5.00 6.00 DOSOD AVMINISTRATULE & CENTRAL. 7.00 7.00 DOTOD OPERATION OF PLANT 7.00 8.00 DOSOD AUDIORY & LINEW SERVICE 8.00 9.00 DOSOD AUDIORY & LINEW SERVICE 8.00 9.00 DOSOD AUDIORY & LINEW SERVICE 8.00 11.00 DISOD AUDIORY & LINEW SERVICE 11.00 12.00 DISOD AUDIORY & LINEW SERVICE 11.00 13.00 DISOD AUDIORY & LINEW SERVICE 11.00 14.00 DISOD AUDIORY & LINEW SERVICE 11.00 15.00 DISOD AUDIORY & LINEW SERVICE 11.00 14.00 DISOD AUDIORY & LINEW SERVICE 11.00 14.00 DISOD AUDIORY & LINEW SERVICE 11.00 10.00 DISOD AUDIORY & LINEW SERVICE 11.00 20.00 DISOD AUDIORY & LINEW SERVICE 21.00 20.00 DISOD AUDIORY & LINEW SERVICE 21.00 21.00 DISOD AUDIORY & LINEW SERVICE 23.00 22.00 DISOD AUDIORY & LINEW SERVICE 23.00 22.00 <						
6.00 00000 M M FLEMARCE & REPAIRS 6.00 7.00 07000 DEBAILON OF PLANT 8.00 9.00						
7.00 00700 DPEANT IN 0 F PLANT 9.00 00000 9.00						
0.00 00000 LANNEY & LINEN SERVICE 9.00 0.00 00000 DESKEPEPINO 9.00 10.00 01000 DETARY 11.00 11.00 01000 DETARY 11.00 11.00 01000 DETARY 11.00 12.00 DETARY 11.00 11.00 12.00 DETARY FENARY 11.00 22.00 DETARY FENARY 11.00 23.00 DETARY FENARY FENARY <tr< td=""><td></td><td></td><td></td><td></td><td></td><td></td></tr<>						
9.00 00000 MULSEREPTING 000000 MULSEREPTING 000000 MULSEREPTING 000000000000000000000000000000000000						
10. 00 01000 DETARY 10. 00 110. 00 01000 CAFTERE IA 11. 00 12. 00 11000 CAFTERE IA 11. 00 12. 00 10200 MARSING ADMINISTANTON 11. 00 13. 00 13.00 13.00 13.00 14. 00 01400 CENTRAL SERVICES & SUPPLY 11. 00 15. 00 15.00 15.00 15.00 15.00 16. 00 15.00 15.00 15.00 15.00 10. 00 10.00 15.00 15.00 15.00 10. 00 10.00 10.00 10.00 10.00 10.00 10. 00 10.00 10.00 10.00 20.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
11:00 01100 CAFETERIA 11:00 12:00 01200 (AMTENANCE OF PERSONRLL 12:00 13:00 01300 NURSI IN COUNCE & SUPPLY 14:00 15:00 01500 (PHRALS, SERVICE'S & SUPPLY 16:00 16:00 01500 (PHRALS, SERVICE'S & SUPPLY 16:00 17:00 01500 (PHRARARY) 17:00 17:00 01500 (PHRARARY) 17:00 17:00 01500 (PHRARARY) 17:00 17:00 0100 (RS ENVICES) 39:350.226 10:00 0100 (PHRARS EVICE) 30:00 10:00 0100 (PHRARS EVICE) 0						
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74.00 07400 RENAL DI ALYSI S 74.00 75.00 07500 ASC (NON-DI STI NCT PART) 0 75.00 76.00 03020 PARTI AL HOSPI TALI ZATI ON 0 76.00 0UTPATI ENT SERVICE COST CENTERS 0 88.00 88.00 88.00 88.00 88.00 89.00 6900 FEDERALLY QUALI FIED HEALTH CENTER 0 89.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 990.00 90.00			-			
75.00 07500 ASC (NON-DI STINCT PART) 0 75.00 76.00 76.00 03020 PARTI AL HOSPI TALIZATION 0 76.00 0UTPATI ENT SERVICE COST CENTERS 88.00 88.00 88.00 88.00 89.00 08800 RURAL HEALTH CLINIC 0 88.00 90.00 09000 CLINIC 0 89.00 90.00 09000 CLINIC 0 90.00 91.00 09100 EMERGENCY 0 91.00 92.00 09200 [085ERVATION BEDS (NON-DI STINCT PART) 92.00 91.00 92.00 092000 [055ERVATION BEDS (NON-DI STINCT PART) 92.00 92.00 9118.00 SUBTOTALS (SUM OF LINES 1-117) 47,077,053 118.00 191.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 47,795 190.00 191.01 19101 PROBATE COURT 146,604 191.00 191.01 19101 PROBATE COURT 146,604 200.00 201.00 Negati ve Cost Centers 0 201.00						
76.00 03020 PARTI AL HOSPI TALI ZATI ON 0 76.00 OUTPATI ENT SERVI CE COST CENTERS 88.00 88.00 88.00 88.00 88.00 0800 RURAL HEALTH CLINIC 0 88.00 90.00 09000 CLINIC 0 99.00 90.00 09000 CLINIC 0 99.00 91.00 09100 EMERGENCY 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 47,077,053 NONREL MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 47,795 191.00 19100 RESEARCH 155,434 191.00 191.01 19101 PROBATE COURT 146,604 191.01 200.00 O Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 200.00						
88.00 08800 RURAL HEALTH CLINIC 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 90.00 09000 CLINIC 0 90.00 91.00 09100 EMERGENCY 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 91.00 SPECIAL PURPOSE COST CENTERS 92.00 92.00 92.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 47,077,053 118.00 100.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 47,795 190.00 19100 RESEARCH 155,434 191.00 191.01 19101 PROBATE COURT 146,604 191.01 200.00 Cross Foot Adjustments 0 200.00 200.00 201.00 Negative Cost Centers 0 201.00 201.00						
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 90.00 09000 CLINIC 0 90.00 91.00 09100 EMERGENCY 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 91.00 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 91.00 91.00 91.00 180.00 SUBTOTALS (SUM OF LINES 1-117) 47,077,053 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 47,795 191.01 19100 RESEARCH 155,434 191.00 191.01 19101 PROBATE COURT 146,604 191.01 200.00 Cross Foot Adjustments 0 200.00 200.00 201.00 Negative Cost Centers 0 201.00 201.00	OUTPATIENT SERVICE	COST CENTERS				
90.00 09000 CLINIC 0 90.00 90.00 91.00 91.00 91.00 92.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 47,077,053 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 47,795 191.00 19100 RESEARCH 155,434 191.01 19101 PROBATE COURT 146,604 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00						
91.00 09100 EMERGENCY 0 91.00 92.00 92.00 0BSERVATI ON BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 47,077,053 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 47,795 191.00 19100 RESEARCH 155,434 191.01 19101 PROBATE COURT 146,604 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00		ALIFIED HEALTH CENTER				
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 47,077,053 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 47,795 190.00 191.00 19100 RESEARCH 155,434 191.00 191.01 19101 PROBATE COURT 146,604 191.01 200.00 Cross Foot Adjustments 0 200.00 201.00						
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 47,077,053 118.00 NONREI MBURSABLE COST CENTERS 190.00 190.00 19T. FLOWER, COFFEE SHOP & CANTEEN 47,795 191.00 19100 RESEARCH 155,434 191.00 191.01 19101 PROBATE COURT 146,604 191.01 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00			0			
118.00 SUBTOTALS (SUM OF LINES 1-117) 47,077,053 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 47,795 190.00 191.00 19100 RESEARCH 155,434 191.00 191.01 19101 PROBATE COURT 146,604 191.01 200.00 Cross Foot Adjustments 0 200.00 201.00						92.00
NONREI MBURSABLE COST CENTERS 190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 47,795 190.00 191.00 191.00 191.00 191.00 191.00 191.00 191.00 191.00 191.00 191.00 200.00 Cross Foot Adjustments 0 200.00 200.00 200.00 201.00 Negative Cost Centers 0 201.00			47 077 053			118 00
190.00 I9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 47,795 190.00 191.00 19100 RESEARCH 155,434 191.00 191.01 19101 PROBATE COURT 146,604 191.01 200.00 Cross Foot Adjustments 0 200.00 201.00			47,077,003			110.00
191.00 RESEARCH 155,434 191.00 191.01 19101 PROBATE COURT 146,604 191.01 200.00 Cross Foot Adjustments 0 200.00 200.00 201.00 Negative Cost Centers 0 201.00			47.795			190.00
191.01 19101 PROBATE COURT 146,604 191.01 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00						
200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00		-				
202.00 TOTAL (sum lines 118-201) 47,426,886 202.00			-			
	202.00 TOTAL (sum li	nes 118-201)	47, 426, 886			202.00

Health Financial Systems	HARRIS CO PSYCH	IATRIC CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	F	Period: From 09/01/2014 To 08/31/2015	Worksheet B Part II	pared:
		CAPI TAL REI	LATED COSTS		1/20/2010 11.	
Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS			1	1		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0			0	2.00 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	0	26, 304		° I	0	5.00
6. 00 00600 MAI NTENANCE & REPAI RS	0	0		0 0	0	6.00
7.00 00700 OPERATION OF PLANT	0	9, 012			0	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	1, 055			0	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0	547 8, 795			0	9.00 10.00
11. 00 01100 CAFETERIA	0	0, 793	0,70		0	11.00
12. 00 01200 MAINTENANCE OF PERSONNEL	0	0		-	0	12.00
13. 00 01300 NURSING ADMINISTRATION	0	2, 180	2, 158	4, 338	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	-	0	14.00
	0	0		-	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0	1, 678	1,66	I 3, 339	0	16.00 17.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0				0	19.00
20. 00 02000 NURSI NG SCHOOL	0	0	(0 0	0	20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVE		0		0 0	0	21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVE) 0	823			0	22.00
23. 00 02300 PARAMED ED PRGM	0	0	(0 0	0	23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 O3000 ADULTS & PEDI ATRI CS	0	88, 108	87, 22	175, 335	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	00,100			0	31.00
45.00 04500 NURSING FACILITY	0	0	(0 0	0	45.00
ANCI LLARY SERVICE COST CENTERS		-		-		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ANCI LLARY SERVI CES	0	0			0	54.00 54.01
54. 01 05401 ANCI LLARY SERVI CES 56. 00 05600 RADI 0I SOTOPE	0	262			0	56.00
57. 00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0 0	0	59.00
60. 00 06000 LABORATORY	0	0	(0	0	60.00
60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0				0	60.01 65.00
66. 00 06600 PHYSI CAL THERAPY	0	0			0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
67. 01 06701 THERAPY SERVICES	0	10, 158			0	67.01
67. 02 03320 ELECTROSHOCK THERAPY	0	1, 603			0	
68.00 06800 SPEECH PATHOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	68.00 71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	, U				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	1, 237	1, 225	2,462	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
75.00 07500 ASC (NON-DI STINCT PART)	0	0	(0	0	75.00
76. 00 03020 PARTI AL HOSPI TALI ZATI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	(0 0	0	76.00
88.00 08800 RURAL HEALTH CLINIC	0	0	(0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89.00
90. 00 09000 CLINIC	0	0	(0	90.00
91. 00 09100 EMERGENCY	0	0	(0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117)	0	151, 762	150, 244	1 302, 006	0	118.00
NONREI MBURSABLE COST CENTERS	0	131,702	1 130, 244	. 502,000	0	1.10.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	524	519	1, 043	0	190.00
191. 00 19100 RESEARCH	0	741				191.00
191.01 19101 PROBATE COURT	0	4, 375	4, 331	8, 706	0	191.01
200.00Cross Foot Adjustments201.00Negative Cost Centers		_		0	0	200.00 201.00
202.00 TOTAL (sum lines 118-201)	0	157, 402	155, 828	3 313, 230	0	201.00
		107, 102	1 100,020	- 010,200	0	

Heal th	Financial Systems	HARRIS CO PSYCH	I ATRI C CENTER		In Lie	u of Form CMS-:	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der	CCN: 454076	Period: From 09/01/2014 To 08/31/2015	Worksheet B Part II Date/Time Pre 1/28/2016 11:	pared: <u>28 am</u>
	Cost Center Description	& GENERAL	MAINTENANCE & REPAIRS	OPERATION O PLANT	F LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00 5.00 6.00	00200 NEW CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	52, 345	0				2.00 4.00 5.00 6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	3, 401		21, 3	35 84 2,618		7.00 8.00
9.00	00900 HOUSEKEEPI NG	625			96 0	1, 809	1
10.00	01000 DI ETARY	2, 261		1, 5		132	1
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	0	-		0 0 0 0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 988		3	81 0	33	
14.00	01400 CENTRAL SERVICES & SUPPLY	0			0 0	0	
15.00 16.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	573	-	2	0 0 93 0	0 25	
17.00	01700 SOCIAL SERVICE	0		2	0 0	0	1
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0		0 0	0	1
20.00		0	-		0 0	0	
21.00 22.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	505		1	0 0 44 0	0	
23.00		0			0 0	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS		1				
30.00 31.00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	32, 547			97 2, 618 0 0	1, 322 0	1
45.00	04500 NURSING FACILITY				0 0	0	1
	ANCI LLARY SERVI CE COST CENTERS		1	1			1
54.00	05400 RADI OLOGY-DI AGNOSTI C	699			0 0	0	54.00
54. 01 56. 00	05401 ANCI LLARY SERVI CES 05600 RADI OI SOTOPE	099			46 0 0 0	4	54.01 56.00
57.00	05700 CT SCAN	0	0		0 0	0	
58.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0	0		0 0	0	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY				0 0	0	1
60.01	06001 BLOOD LABORATORY	0	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0		0 0 0 0	0	66.00
67.00 67.01	06701 THERAPY SERVICES	4, 259	-	1, 7	-	0 153	67.00 67.01
67.02	03320 ELECTROSHOCK THERAPY	203			80 0	24	1
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS				0 0	0	1
	07300 DRUGS CHARGED TO PATIENTS	2, 578		2	16 0	19	
	07400 RENAL DIALYSIS	0			0 0	0	74.00
	07500 ASC (NON-DI STINCT PART) 03020 PARTI AL HOSPI TALI ZATI ON				0 0 0 0	0	1
78.00	OUTPATIENT SERVICE COST CENTERS	1 0	η 0		0 0	0	78.00
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	1
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
90.00 91.00	09000 CLI NI C 09100 EMERGENCY				0 0	0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS				0		92.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	52, 192	0	20, 3	49 2, 618	1, 724	118. 00
190. 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1	0		92 0	8	190.00
	19100 RESEARCH	141	-		30 0		191.00
	1 19101 PROBATE COURT	11	0	7	64 0	66	191.01
200.00 201.00					0	0	200. 00 201. 00
201.00		52, 345	0	21, 3	35 2,618		201.00
					_, 510	., 507	

Induction of the Unit Multiple Construction of the	Health Financial Systems	HARRIS CO PSYCHI		CCN: 454076	In Lie Period:	eu of Form CMS- Worksheet B	2552-10
Cost Center Description DIETAY CAFETERIA MAINTENANCE OF DURING CENTRAL SERVICE BEREMAL SERVICE COST CENTERS 10.00 11.00 12.00 13.00 13.00 10.00 10.00 00000 (PERTON IN CAR INT IN A FIRITION CONTROL AND INTENTION CAR INTERIANCE AND IN ELEMAN SERVICE COST CENTERS 1.00 13.00 1.00 10.00 <td< td=""><td>ALLOCATION OF CALLIAL RELATED COSTS</td><td></td><td>TTOVIDEI</td><td>CCN. 454070</td><td>From 09/01/2014</td><td> Part II 5 Date/Time Pre</td><td>epared: 28 am</td></td<>	ALLOCATION OF CALLIAL RELATED COSTS		TTOVIDEI	CCN. 454070	From 09/01/2014	Part II 5 Date/Time Pre	epared: 28 am
EVENEN_SERVICE COST CENTERS 1.00 0.00000 MER CAP REL COSTS-NUELE EQUIP 2.00 2.00 0.0000 MER CAP REL COSTS-NUELE EQUIP 2.00 0.00000 MER CAP REL COSTS-WORLE EQUIP 2.00 0.00000 MER CAP REL COSTS-WORLE EQUIP 2.00 0.00000 MENTERS MER TO REPARTS 0.00 0.00000 MENTERS MER TO REPARTS 0.00 0.00000 CUMINETS MER THE MER TO REPARTS 0.00 0.000000 CUMINETS MER THE MER TO REPARTS 0.00 0.00000000000000000000000000000000000	Cost Center Description	DI ETARY	CAFETERI A			CENTRAL SERVICES &	
1.00 DOTON NEW CAP BEL COSTS-BLID & FLYT 1.00 2.00 DOTON NEW CAP BEL COSTS-BLID & FLYT 1.00 2.00 DOTON NET CAPPL COSTS-BLID & FLYT 4.00 4.00 DOTON NET STATURE & CORFARL 5.00 5.00 DOTON DEFEART NO F PLANT 6.00 5.00 DOTON DEFEART NO F PLANT 6.00 5.00 DOTON DEFEART FLYT 0 5.00 DOTON DEFEART FLYT 0 0 5.00 DOTON DEFEART FLYT 0 0 0 5.00 DOTON DEFEART SERVICES ADDEFEART 1.00 1.100 1.100 5.00 DOTON DEFEART SERVICES ADDEFEART 0 0 0 0 0 0 0 1.100 5.00 DOTON DOND DEFEART SERVICES ADDEFEART 0 0 0 0 0 0		10.00	11.00	12.00	13.00	14.00	
2.00 00200 KW CAP REL COSTS-WELE COUT - VALUES EQUIP - 2.00 00200 KW CAP REL COSTS-WELE EQUIP - 4.00 - 5.00 00500 AUXIN ISTANCE & PERSONAL - 6.00 - 5.00 00500 AUXIN ISTANCE & PERSONAL - 6.00 - 7.740 - 11.00 10.00 OUGSEREEP ING - 7.740 - 11.00 11.00 OUGSEREEP ING - 7.740 - 0.0 0 - 0.0 0 - 10.00 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 -				1		1	1 1 00
4.00 00400 NAMO (NR) STRATUS & GENERAL 4.00 0.00 00500 AMIN ISTRATUS & GENERAL 5.00 0.00 00500 AMIN STRATUS & GENERAL 5.00 0.00 00500 AMIN STRATUS & GENERAL 7.00 0.00 00500 AMIN STRATUS & GENERAL 7.00 0.00 00500 CAMINETRATUS & LINES SERVICE 0 11.00 0.00 01000 CARETRAL SERVICE 0 0 12.00 0.00 01000 CARETRAL SERVICE 0 0 12.00 11.000 01300 BURSIN S. AMIN STRATION 0 0 0 13.00 13.00 01300 BURSIN S. SCHARDSE & LIBRARY 0 0 0 14.00 14.00 10000 FRARMANCE REPARIDER FOR COSTA 0 0 0 14.00 15.00 01000 RESENCES-DENER FOR COSTA SERVICE 0 0 0 21.00 22.00 20.00 20.00 CARETRAL SERVICES-SCHARDY 0 0 0<							
6.00 00000 JALIN ITENNINCE & REPAIRS 6.00 7.00 00000 DERATION OF PLANT 7.00 8.00 00000 DERATION OF PLANT 7.00 7.00 7.00 7.00 9.00 00000 DERALEPIN & LINES SERVICE 9.00 9.00 9.00 10.00 DIODES KLEPIN 0.00 0.000 11.00 11.00 10.00 DIODES KLEPIN 0.00 0.000 0.000 11.00 10.00 DIODES KLEPIN 0.00 0.000 0.000 11.00 11.00 DIODES KLEPIN 0.00 0.00 0.000 11.00 11.00 DIODES KLEPIN SAURINISTRATION 0.00 0.00 0.00 11.00 11.00 DIODES KLEPIN SAURINISTRATION 0.00 0.00 0.00 11.00 11.00 11.00 DIODES KLEPINS 0.00 0.00 0.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00							
7.00 00700 OPENATION OF FLANT 7.00 9.00 00900 AUNRY & LIENS SERVICE 9.00 9.00 00900 FLARY 21,432 9.00 11.00 01100 CHTRAY 0 0 0.00 12.00 01100 CHTRAY 0 0 0 10.00 13.00 01300 DESKNELL 0 0 0 14.00 13.00 01300 DESKNELL 0 0 0 14.00 14.00 DESKNELL 0 0 0 0 14.00 14.00 DESKNELL 0 0 0 0 15.00 15.00 DESOCHASSKELL 0 0 0 0 17.00 10.00 DESOCHASSKELL 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>5.00</td>							5.00
B. 00 00000 (LAUNDRY & LINEN SERVICE 8.00 00 00000 (DIETARY 21,432 10.00 01000 (DIETARY 21,432 11.00 01000 (DIETARY 0 12.00 01000 (DIETARY 0 13.00 01000 (DIETARY 0 0 14.00 01000 (DIETARY 0 0 0 15.00 01500 (DIETARY 0 0 0 0 10.00 01000 (DIETARY 0 0 0 0 0 11.00 01000 (DIETARY 0							
9.00 00900 HOUSEKEEPING 10.00 01000 IFTARY 10.00 0100 IFTARY 10.00 000 IFTARY 10.00 000 IFTARY 10.00 000 IFTARY 10.00 000 IFTARY 10.00 000 IFTARY 10.00 000 IFTARY 10.00 00							
10.00 01000 DIETARY 21, 432 0							
11.00 01100 CAFETERIA 0 0 11.00 11.00 12.00 01200 (MURS) IN ADMINISTRATION 0 0 0 7,740 13.00 13.00 01300 (MURS) IN CAMINISTRATION 0 0 0 0 13.00 14.00 01400 (CHETRAL SERVICE S & SUPPLY) 0 0 0 0 0 14.00 15.00 01500 (PHAMAACY 0 0 0 0 0 0 0 15.00 10.00 01500 (MURS) IN SCHOL ERVICE S ASUPPLY 0 0 0 0 0 17.00 10.00 01500 (MURS) IN SCHOL C 0		21, 432					
13.00 01300 NURSING ADMINISTRATION 0 0 7,740 13.00 14.00 01400 CHTRAL SERVICES & SUPPLY 0 0 0 0 14.00 15.00 01500 PHARAMCY 0			C	þ			
14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 15.00 15.00 01500 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 15.00 17.00 01700 NUMENINS SOCIAL SERVICE 0 <td< td=""><td></td><td>0</td><td>C</td><td>)</td><td>0</td><td></td><td>12.00</td></td<>		0	C)	0		12.00
15. 00 01500 PHARMACY 0 0 0 0 15. 00 16. 00 01500 MEDICAL RECORDS & LIBRARY 0 0 0 0 16. 00 16. 00 17. 00 17. 00 17. 00 19. 00 19. 00 0		0	C				
16.00 01400 MEDICAL RECORDS & LIBRARY 0		0	(-		
17. 00 01700 SQC1AL SERVICE 0 0 0 0 0 0 17. 00 19. 00 01000 NORHMYSICLAL ANESTHETISTS 0		0	(-		
19.00 001900 NUMPSING CARN ANESTHETI STS 0		0	C				
11.00 02100 148 SERVI CES-SALARY & FRINGES APPRVD 0 0 0 0 0 0 0 0 0 23.00 22.00 148 SERVI CES-SALARY & FRINGES APPRVD 0 0 0 0 23.00 23.00 23.00 0 0 0 0 0 0 23.00 23.00 0 <t< td=""><td></td><td>0</td><td>C</td><td></td><td>0 0</td><td>0</td><td></td></t<>		0	C		0 0	0	
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INPATI ENT NOUTINE SERVICE COST CENTERS 1 1 00 0000 ADULTS & PEDIATRI CS 21,161 0 0 740 0 30.00 31:00 0000 NURSING FACILITY 0						-	
30.00 03000 ADULTS & PEDIATRICS 21,161 0 0 7,740 0 30.00 41.00 03100 0 0 0 0 0 0 31.00 43.00 04500 NURSING FACILITY 0		0	Ĺ	<u>и</u>		<u> </u>	23.00
45. 00 OdsOr() NURSING FACILITY O O O 45. 00 ANCILLARY SERVICE COST CENTERS 0 0 0 0 54. 00 54. 00 0 0 0 0 54. 00 54. 00 54. 00 0 <t< td=""><td></td><td>21, 161</td><td>C</td><td>)</td><td>0 7,740</td><td>0 0</td><td>30.00</td></t<>		21, 161	C)	0 7,740	0 0	30.00
ARCILLARY SERVICE COST CENTERS Image: Control Advisory of Contrel Advisory of Control Advisory of Contrel Advisory of Contrel							
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54.01 OS401 ANCI LLARY SERVICES 0 0 0 54.01 56.00 OS6000 RADIO IS STOPE 0 0 0 0 57.00 57.00 DS700 CT SCAN 0 0 0 0 0 57.00 58.00 OS600 CARDIA C CATHETERI ZATION 0		0		ป	0 0		54 00
66.00 0500 CARLOI SOTOPE 0 0 0 0 0 0 57.00 57.00 05700 CT SCAN 0 0 0 0 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0<							
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0		0	C		0 0	0 0	56.00
59.00 05900 CARDIAC CATHETERIZATION 0		0	C		0 0		
60.00 06000 LABORATORY 0		0	0				
60.01 06001 BLODD LABORATORY 0 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>-</td> <td></td>		0				-	
65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 65.00 66.00 0660.00 00 0 <td< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></td<>		0					
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67.01 06701 THERAPY SERVICES 0 0 0 0 67.01 67.02 03202 ELECTROSHOCK THERAPY 0 0 0 0 67.02 68.00 OB600 SPECH PATHOLOGY 0 0 0 0 67.02 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 RUGS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75.00 00200 PARTI AL HOSPI TALIZATION 0 0 0 0 0 76.00 00100 B800 REARCH 0 0 0 0 0 88.00 89.00 08000 FEDERALTH CLINIC 0 0 0 0 91.00	66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0 0	66.00
67. 02 03320 ELECTROSHOCK THERAPY 0 0 0 0 0 67. 02 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 68. 00 71. 00 OTOO MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71. 00 72. 00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73. 00 74. 00 O7400 RENAL DI ALYSI S 0 0 0 0 74. 00 75. 00 O7500 ASC (NON-DI STI NCT PART) 0 0 0 0 75. 00 76. 00 O3020 PARTI AL HOSPI TALI ZATI ON 0 0 0 0 76. 00 00 0800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00 89. 00 90. 00 08000 RURAL HEALTH CLINIC 0 0 0 0 90. 00 90. 00 90. 00 90. 00 91. 00 91. 00 91.		0	C		0 0		
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71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75.00 76.00 03020 PARTI AL HOSPI TALIZATION 0 0 0 0 0 76.00 00000 DUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 76.00 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 0 90.00		0					
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 C7400 RENAL DIALYSIS 0 0 0 0 74.00 75.00 O7500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 76.00 03020 PARTIAL HOSPITALIZATION 0 0 0 0 75.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 88.00 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 88.00 90.00 09000 CLINIC 0 0 0 0 89.00 89.00 0 0 90.00 <t< td=""><td></td><td>0</td><td>C</td><td></td><td>0 0</td><td></td><td></td></t<>		0	C		0 0		
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75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 76.00 03020 PARTIAL HOSPITALIZATION 0 0 0 0 0 76.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 76.00 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 99.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 90.00 09000 CLINIC 0 0 0 0 89.00 90.00 09000 EMERGENCY 0 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 </td <td></td> <td>0</td> <td>C</td> <td>0</td> <td>0 0</td> <td></td> <td></td>		0	C	0	0 0		
76.00 03020 PARTI AL HOSPI TALI ZATI ON 0 0 0 0 0 0 0 0 0 76.00 OUTPATI ENT SERVICE COST CENTERS		Ű	(
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 09000 CLINIC 0 0 0 0 0 89.00 90.00 09100 EMERGENCY 0 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 91.00 92.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 21, 161 0 0 7,740 0 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 271 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 191.01 191.01 PROBATE COURT 0							
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 91.00 92.00		1 9		·1		<u>, </u>	10100
90.00 09000 CLINIC 0 0 0 0 90.00 91.00 91.00 92.00		0	C)	0 0		
91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 21,161 0 0 7,740 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 271 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 191.00 191.01 19101 PROBATE COURT 0 0 0 0 191.01 200.00 Cross Foot Adj ustments 0 0 0 0 200.00 201.00 Negati ve Cost Centers 0 0 0 0 0 201.00		0	C		0 0		
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 21,161 0 0 7,740 0 NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 271 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 191.00 191.01 PROBATE COURT 0 0 0 0 191.01 200.00 Cross Foot Adj ustments 200.00 201.00 0 0 0 0 201.00		0	0		0 0		
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 21,161 0 0 7,740 0 190.00 1900.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 271 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 191.00 191.01 19101 PROBATE COURT 0 0 0 0 191.01 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00		0	Ĺ		0 0		
NONREI MBURSABLE COST CENTERS 190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 271 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 191.00 191.01 19100 RESEARCH 0 0 0 0 191.00 191.01 19101 ROBATE COURT 0 0 0 191.01 200.00 Cross Foot Adjustments 200.00 201.00 0 0 0 201.00							72.00
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 271 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 191.00 191.01 19101 PROBATE COURT 0 0 0 0 191.01 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00		21, 161	C		0 7,740	0 0	118.00
191.00 19100 RESEARCH 0 0 0 191.00 191.01 19101 PROBATE COURT 0 0 0 0 191.01 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0							1.00.00
191.01 19101 PROBATE COURT 0 0 0 191.01 200.00 Cross Foot Adjustments 200.00 200.00 200.00 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00	191 OO 1910O RESEARCH	1					
200.00 Cross Foot Adjustments 200.00		0	ſ	Ś			
201.00 Negative Cost Centers 0 </td <td></td> <td>0</td> <td>C</td> <td></td> <td></td> <td>1</td> <td></td>		0	C			1	
202.00 TOTAL (sum lines 118-201) 21,432 0 0 7,740 0/202.00	201.00 Negative Cost Centers	0	C		0 0		201.00
	202.00 TOTAL (sum lines 118-201)	21, 432	C)	0 7,740	0 0	202.00

Health Financial Systems	HARRIS CO PSYCHI	ATRIC CENTER		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	F	eriod: rom 09/01/2014 o 08/31/2015	Date/Time Pre	pared:
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	1/28/2016 11: NURSI NG SCHOOL	28 am
	15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS	1 1		1		1	1 1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
6. 00 00600 MAI NTENANCE & REPAI RS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8.00 9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERIA						11.00
12.00 01200 MAI NTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	4, 230				15.00 16.00
17. 00 01700 SOCIAL SERVICE	0	4,230				17.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	C		19.00
20. 00 02000 NURSI NG SCHOOL	0	0	0		0	20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0			21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0				22.00
23. 00 02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0			23.00
30. 00 03000 ADULTS & PEDIATRICS	0	3, 820	0			30.00
31.00 03100 I NTENSI VE CARE UNI T	0	0				31.00
45.00 04500 NURSING FACILITY	0	0	0			45.00
	0	0	0		1	1 54 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ANCI LLARY SERVI CES	0	0 32				54.00 54.01
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57.00 05700 CT SCAN	0	0	0			57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0			58.00
59. 00 05900 CARDIAC CATHETERIZATION 60. 00 06000 LABORATORY	0	0	0			59.00
60. 01 06000 LABORATORY	0	0	0			60.00 60.01
65. 00 06500 RESPI RATORY THERAPY	0	0	0			65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
67. 01 06701 THERAPY SERVICES 67. 02 03320 ELECTROSHOCK THERAPY	0	154	0			67.01
67. 02 03320 ELECTROSHOCK THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	8	0			67.02 68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	-			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	216	0			73.00
74.00 07400 RENAL DIALYSIS	0	0	0			74.00
75. 00 07500 ASC (NON-DI STI NCT PART) 76. 00 03020 PARTI AL HOSPI TALI ZATI ON	0	0	0			75.00 76.00
OUTPATIENT SERVICE COST CENTERS	0	0			1	/ 0. 00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0			88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	0	0	0			90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0			91.00 92.00
SPECIAL PURPOSE COST CENTERS				I		,2.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	4, 230	0	C	0	118.00
NONREI MBURSABLE COST CENTERS		-	-			100.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH	0	0	0			190. 00 191. 00
191. 00 19100 RESEARCH 191. 01 19101 PROBATE COURT		0				191.00
200.00 Cross Foot Adjustments		0	Ĭ	C	0	200.00
201.00 Negative Cost Centers	0	0	0	C	0	201.00
202.00 TOTAL (sum lines 118-201)	0	4, 230	0	C	0 0	202.00

Heal th	Financial Systems	HARRIS CO PSYCH	II ATRI C CENTI	ER	In Lie	eu of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi d	er CCN: 454076	Period: From 09/01/2014	Worksheet B Part II	
					To 08/31/2015	Date/Time Pre	
		INTERNS &	RESI DENTS			1/28/2016 11:	28 am
	Cost Center Description	SERVICES-SALAR Y & FRINGES	SERVICES-OTH PRGM COSTS) Subtotal	Intern & Residents Cost	
						& Post	
						Stepdown Adjustments	
		21.00	22.00	23.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS		I			I	
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY 01100 CAFETERI A						10.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14.00 15.00
	01600 MEDI CAL RECORDS & LI BRARY						16.00
	01700 SOCIAL SERVICE						17.00
	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL						19.00 20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	505					21.00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		3, (012			22.00
23.00	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS				0		23.00
	03000 ADULTS & PEDI ATRI CS				259, 940		1
	03100 INTENSIVE CARE UNIT 04500 NURSING FACILITY				0		
45.00	ANCI LLARY SERVICE COST CENTERS					0	45.00
	05400 RADI OLOGY-DI AGNOSTI C				0		1
54. 01 56. 00	05401 ANCI LLARY SERVI CES 05600 RADI OI SOTOPE				1, 302 0		
	05700 CT SCAN				0	0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)				0	0	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY				0	0	59.00 60.00
	06001 BLOOD LABORATORY				0	0	
65.00	06500 RESPI RATORY THERAPY				0	0	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY				0	0	
	06700 THERAPY SERVICES				26, 556		1
67.02	03320 ELECTROSHOCK THERAPY				3, 705	0	67.02
	06800 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS				0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS				5, 491	0	73.00
74.00	07400 RENAL DIALYSIS				0	-	1
	07500 ASC (NON-DI STI NCT PART) 03020 PARTI AL HOSPI TALI ZATI ON				0	0	1
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC				0	-	
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC				0	0	
	09100 EMERGENCY				0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	0		0	0 296, 994	0	118.00
	NONREI MBURSABLE COST CENTERS				0 270,774		1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				1, 415		190.00
	19100 RESEARCH 19101 PROBATE COURT				1, 757 9, 547		191.00 191.01
200.00		505	3, 0	012	0 3, 517		200.00
201.00	Negative Cost Centers	0		0	0 0		201.00
202.00	TOTAL (sum lines 118-201)	505	3, (012	0 313, 230	0	202.00

ALLOCAT	ION OF CAPITAL RELATED COSTS		Provider CCN: 454076	Period: Worksheet From 09/01/2014 Part II	
				To 08/31/2015 Date/Time 1/28/2016	
	Cost Center Description	Total 26.00			
(GENERAL SERVICE COST CENTERS	20.00			
. 00 0	DO100 NEW CAP REL COSTS-BLDG & FIXT				1. (
	DO200 NEW CAP REL COSTS-MVBLE EQUIP				2.0
	00400 EMPLOYEE BENEFITS DEPARTMENT				4. (
	00500 ADMI NI STRATI VE & GENERAL				5.0
	DOGOO MAINTENANCE & REPAIRS				6.0
	00700 OPERATION OF PLANT				7.0
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING				8.0
	DI ETARY				10. (
	D1100 CAFETERI A				11. 0
	D1200 MAINTENANCE OF PERSONNEL				12.0
	01300 NURSI NG ADMI NI STRATI ON				13. (
4.00	01400 CENTRAL SERVICES & SUPPLY				14. (
5.00	D1500 PHARMACY				15.0
	01600 MEDICAL RECORDS & LIBRARY				16. (
	01700 SOCIAL SERVICE				17.0
	01900 NONPHYSI CI AN ANESTHETI STS				19.0
	D2000 NURSING SCHOOL				20.0
	D2100 I &R SERVI CES-SALARY & FRI NGES APPRVD D2200 I &R SERVI CES-OTHER PRGM COSTS APPRVD				21. (
	02300 PARAMED ED PRGM				22.0
-	NPATIENT ROUTINE SERVICE COST CENTERS				25.0
-	D3000 ADULTS & PEDIATRICS	259, 940			30.0
	D3100 I NTENSI VE CARE UNI T	0			31. 0
5.00	D4500 NURSING FACILITY	0			45.0
	ANCILLARY SERVICE COST CENTERS				
	05400 RADI OLOGY-DI AGNOSTI C	0			54.0
	05401 ANCI LLARY SERVI CES	1, 302			54.0
	D5600 RADI OI SOTOPE	0			56.0
	D5700 CT_SCAN D5800 MAGNETIC_RESONANCE_IMAGING_(MRI)	0			57.0 58.0
	05900 CARDI AC CATHETERI ZATI ON	0			59.0
	D6000 LABORATORY	0			60.0
	D6001 BLOOD LABORATORY	0			60.0
	06500 RESPI RATORY THERAPY	0			65.0
6.00	D6600 PHYSI CAL THERAPY	0			66. (
	06700 OCCUPATI ONAL THERAPY	0			67.0
	D6701 THERAPY SERVICES	26, 556			67.0
	03320 ELECTROSHOCK THERAPY	3, 705			67.0
	06800 SPEECH PATHOLOGY	0			68.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0			71.0
	07300 DRUGS CHARGED TO PATIENTS	5, 491			72.0
	07400 RENAL DI ALYSI S	0			74.0
	07500 ASC (NON-DI STINCT PART)	0			75.0
	03020 PARTIAL HOSPITALIZATION	0			76. (
-	DUTPATIENT SERVICE COST CENTERS	1			
	D8800 RURAL HEALTH CLINIC	0			88.0
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			89.0
		0			90.0
	D9100 EMERGENCY D9200 OBSERVATION BEDS (NON-DISTINCT PART)	0			91. (92. (
	SPECIAL PURPOSE COST CENTERS				92.0
18.00	SUBTOTALS (SUM OF LINES 1-117)	296, 994			118. 0
	NONREI MBURSABLE COST CENTERS	2,0,7,1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 415			190. (
	19100 RESEARCH	1, 757			191. (
	19101 PROBATE COURT	9, 547			191. (
200.00	Cross Foot Adjustments	3, 517			200. 0
201.00	Negative Cost Centers	0			201. (
02.00	TOTAL (sum lines 118-201)	313, 230			202. (

I AL	LOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1	
					rom 09/01/2014 o 08/31/2015		pai
		CAPI TAL REL	ATED COSTS			1/28/2016 11:	28
	Cost Center Description	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS	Reconciliation	ADMINISTRATIVE & GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
				SALARI ES)			
0	ENERAL SERVICE COST CENTERS	1.00	2.00	4.00	5A	5.00	+
_	DOTOO NEW CAP REL COSTS-BLDG & FIXT	148, 599					1
	00200 NEW CAP REL COSTS-MVBLE EQUIP	,	148, 599				
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	31, 311, 805			
	00500 ADMINISTRATIVE & GENERAL	24, 833	24, 833	3, 630, 399	-8, 565, 267	40, 503, 204	
	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0 8, 508	0 500		0	0	
	00800 LAUNDRY & LINEN SERVICE	8, 508 996	8, 508 996	1, 054, 969	0	2, 632, 335 259, 563	
	00900 HOUSEKEEPI NG	516	516	C	0	483, 518	
00 0	D1000 DI ETARY	8, 303	8, 303	C	0	1, 750, 090	1
	01100 CAFETERIA	0	0	C	0	0	
	01200 MAINTENANCE OF PERSONNEL			1 457 007	0	0	
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	2, 058	2, 058	1, 657, 237	0	2, 312, 691 0	
	01500 PHARMACY	0	0	1	0	0	
	01600 MEDICAL RECORDS & LIBRARY	1, 584	1, 584	331, 613	o o	443, 508	
	01700 SOCIAL SERVICE	0	0	C	0	0	
	01900 NONPHYSI CLAN ANESTHETI STS	0	0	C	0	0	
	02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	294, 573	0	0 390, 854	
	2200 I&R SERVICES-OTHER PRGM COSTS APPRVD	777	777	294, 573	0	943, 052	
	2300 PARAMED ED PRGM	0	0	C		0	
I	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	83, 181	83, 181	20, 844, 926		25, 178, 475	
	03100 INTENSIVE CARE UNIT	0	0	C	0	0	-
	04500 NURSI NG FACILITY NCILLARY SERVICE COST CENTERS	0	0	C	0	0	4
	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	5
	05401 ANCI LLARY SERVI CES	247	247	45, 205	0	541, 138	5
	05600 RADI OI SOTOPE	0	0	C	0	0	-
	05700 CT SCAN	0	0	C	0	0	
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0		0	0	-
	06000 LABORATORY	0	0	C	0	0	
01 C	06001 BLOOD LABORATORY	0	0	C	0	0	6
	06500 RESPI RATORY THERAPY	0	0	C	0	0	-
	06600 PHYSI CAL THERAPY	0	0	C	0	0	-
	06700 OCCUPATI ONAL THERAPY 06701 THERAPY SERVI CES	9, 590	9, 590	2, 419, 097	0	0 3, 296, 409	
	03320 ELECTROSHOCK THERAPY	1, 513	1, 513	48, 957		157, 122	
	06800 SPEECH PATHOLOGY	0	0	C	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	002 501	0	1 005 424	17
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	1, 168 0	1, 168 0	903, 591	0	1, 995, 434 0	
	07500 ASC (NON-DI STI NCT PART)	0	0	C	0	0	
00 0	03020 PARTI AL HOSPI TALI ZATI ON	0	0	C	0	0	
С	DUTPATIENT SERVICE COST CENTERS						4.
	08800 RURAL HEALTH CLINIC	0	0	C	0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	-
	09100 EMERGENCY	0	0	C	0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						9
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					4
. 00	SUBTOTALS (SUM OF LINES 1-117) IONREI MBURSABLE COST CENTERS	143, 274	143, 274	31, 230, 567	-8, 565, 267	40, 384, 189	111
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	495	495	C	0	1, 043	19
	19100 RESEARCH	700	700	81, 238	o o	109, 266	19
	19101 PROBATE COURT	4, 130	4, 130	C	0	8, 706	
. 00	Cross Foot Adjustments						20
. 00	Negative Cost Centers Cost to be allocated (per What B	157 400	155 000	10 224 250		0 EKE 9/7	20
. 00	Cost to be allocated (per Wkst. B, Part I)	157, 402	155, 828	10, 234, 250		8, 565, 267	20
. 00	Unit cost multiplier (Wkst. B, Part I)	1. 059240	1. 048648	0. 326850		0. 211471	20
. 00	Cost to be allocated (per Wkst. B,			C		52, 345	
	Part II)						_
. 00	Unit cost multiplier (Wkst. B, Part	1		0.00000)	0.001292	20

Health Financial Systems	Н	IARRIS CO PSYCHI	ATRIC CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICA	AL BASIS		Provi der		eriod: rom 09/01/2014	Worksheet B-1	
					08/31/2015	Date/Time Pre 1/28/2016 11:	
Cost Center Desc	cription	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TIME SPENT)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS)	
		6.00	7.00	8.00	9.00	10.00	
1.00 GENERAL SERVICE COST							1.00
2.00 00200 NEW CAP REL COS 4.00 00400 EMPLOYEE BENEFI 5.00 00500 ADMI NI STRATI VE a 6.00 00600 MAI NTENANCE & RI 7.00 00700 OPERATI ON OF PL/ 8.00 00800 LAUNDRY & LI NEN 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 12.00 01200 MAI NTENANCE OF I 13.00 01300 NURSI NG ADMI NI S' 14.00 01400 CENTRAL SERVICES 15.00 01600 MEDI CAL RECORDS	TS-MVBLE EQUI P TS DEPARTMENT & GENERAL EPAI RS ANT SERVI CE PERSONNEL TRATI ON S & SUPPLY	123, 766 8, 508 996 516 8, 303 0 0 2, 058 0 0 0 1, 584	115, 258 996 516 8, 303 0 2, 058 0 0 1, 584	100 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	113, 746	251, 376 0 0 0 0 0 0 0 0 0 0	2.00 4.00 5.00 6.00 7.00 8.00 9.00
17.00 01700 SOCI AL SERVICE 19.00 01900 NONPHYSICIAN ANI 20.00 02000 NURSING SCHOOL 21.00 02100 I&R SERVICES-SAI 22.00 02200 I&R SERVICES-SAI	LARY & FRINGES APPRVD	0 0 0 777	0 0 0 777	0 0 0 0 0	0 0 0 777	0 0 0 0 0	17.00 19.00 20.00 21.00 22.00
23.00 02300 PARAMED ED PRGM	VICE COST CENTERS	0	0	0	0	0	23.00
30. 00 03000 ADULTS & PEDI ATI 31. 00 03100 I NTENSI VE CARE I 45. 00 04500 NURSI NG FACI LI T	RI CS JNI T	83, 181 0 0	83, 181 0 0	100 0 0	0	248, 202 0 0	30.00 31.00 45.00
ANCI LLARY SERVICE COS		0	0	0	<u> </u>	0	45.00
54.00 05400 RADI OLOGY-DI AGNO 54.01 05401 ANCI LLARY SERVIO 56.00 05600 RADI OL SOTOPE 57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONAL	CES NCE IMAGING (MRI)	0 247 0 0 0	0 247 0 0 0	0 0 0 0 0	247 0 0 0	0 0 0 0 0	54.00 54.01 56.00 57.00 58.00
59.00 05900 CARDI AC CATHETEI 60.00 06000 LABORATORY 60.01 06001 BLOOD LABORATORY 65.00 06500 RESPI RATORY THEI 66.00 06600 PHYSI CAL THERAPY	Y RAPY Y	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	59.00 60.00 60.01 65.00 66.00
67.00 06700 OCCUPATI ONAL THI 67.01 06701 THERAPY SERVICES 67.02 03320 ELECTROSHOCK THI 68.00 06800 SPEECH PATHOLOG 71.00 07100 MEDI CAL SUPPLIES	S ERAPY Y S CHARGED TO PATIENTS	0 9, 590 1, 513 0 0	0 9, 590 1, 513 0 0	000000000000000000000000000000000000000	0 9, 590 1, 513 0 0	0 0 0 0	67.00 67.01 67.02 68.00 71.00
72. 00 07200 I MPL. DEV. CHARG 73. 00 07300 DRUGS CHARGED TO 74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STI NO 76. 00 03020 PARTI AL HOSPITAL	DI PATI ENTS CTI PART) LI ZATI ON	0 1, 168 0 0 0	0 1, 168 0 0 0	0 0 0 0	0 1, 168 0 0 0	0 0 0 0	73.00 74.00 75.00
OUTPATI ENT SERVICE CO 88.00 OB800 RURAL HEALTH CLI 89.00 08900 FEDERALLY QUALI I 90.00 09000 CLI NI C 91.00 09100 EMERGENCY 92.00 09200 OBSERVATI ON BEDS	INIC FIED HEALTH CENTER S (NON-DISTINCT PART)	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	88.00 89.00 90.00 91.00 92.00
SPECI AL PURPOSE COST 118.00 SUBTOTALS (SUM (NONREI MBURSABLE COST	OF LINES 1-117)	118, 441	109, 933	100	108, 421	248, 202	118. 00
190.00 19000 GIFT, FLOWER, CO 191.00 19100 RESEARCH 191.01 19101 PROBATE COURT 200.00 Cross Foot Adjus 201.00 Negative Cost Co	OFFEE SHOP & CANTEEN	495 700 4, 130	495 700 4, 130	0 0 0		0	190.00 191.00 191.01 200.00 201.00
202.00 Cost to be allow Part I)	cated (per Wkst. B,	О	3, 188, 998			2, 393, 714	
203.00 Unit cost multi	olier (Wkst. B, Part I) cated (per Wkst. B,	0. 000000 0	27. 668344 21, 335	3, 420. 110000 2, 618		9. 522444 21, 432	203. 00 204. 00
	olier (Wkst. B, Part	0. 000000	0. 185106	26. 180000	0. 015904	0. 085259	205.00

Heal th	Financial Systems	HARRIS CO PSYCH	IATRIC CENTER		In Lie	u of Form CMS-	2552-10
	LOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
					From 09/01/2014 To 08/31/2015	Date/Time Pre	
	Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSING	CENTRAL	1/28/2016 11: PHARMACY	28 am
	cost center bescription	(MEALS SERVED)	PERSONNEL	ADMI NI STRATI ON		(COSTED	
			(NUMBER		SUPPLY	REQUIS.)	
			HOUSED)	(TIME SPENT)	(COSTED REQUIS.)		
		11.00	12.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS	T	Γ	T	1		
	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINI STRATI VE & GENERAL						5.00
	00600 MAI NTENANCE & REPAI RS						6.00
	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00 9.00
	01000 DI ETARY						10.00
	01100 CAFETERI A	0					11.00
	01200 MAINTENANCE OF PERSONNEL	0	0				12.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0) 100			13.00 14.00
	01500 PHARMACY	0				0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16.00
	01700 SOCIAL SERVICE	0	0		-	0	17.00
	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0			-	0	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0			-	0	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0		-	0	
-	02300 PARAMED ED PRGM	0	0		0 0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	0	C	100	0	0	1 20 00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0				0	30.00 31.00
	04500 NURSI NG FACI LI TY	0				0	
	ANCI LLARY SERVI CE COST CENTERS		I	1	1		
	05400 RADI OLOGY-DI AGNOSTI C 05401 ANCI LLARY SERVI CES	0				0	
	05600 RADI OI SOTOPE	0				0	
	05700 CT SCAN	0	0			0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	0 0	-	0	58.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0			-	0	
	06001 BLOOD LABORATORY	0			-	0	
	06500 RESPI RATORY THERAPY	0	0) (0 0	0	65.00
	06600 PHYSI CAL THERAPY	0	C) (0 0	0	
	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
	06701 THERAPY SERVI CES 03320 ELECTROSHOCK THERAPY	0				0	
	06800 SPEECH PATHOLOGY	0	0		0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0				0	
	07500 ASC (NON-DISTINCT PART)	0				0	
76.00	03020 PARTI AL HOSPI TALI ZATI ON	0	0		0	0	
					ol ol	0	88.00
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	
	09000 CLINIC	0	0		0	0	
	09100 EMERGENCY	0	C		0 0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	0	C	100		0	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C) (0		190.00
	19100 RESEARCH	0			0		191.00
200.00	19101 PROBATE COURT Cross Foot Adjustments	0		, (0	191. 01 200. 00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	0	C	2, 869, 556	6 O	0	202.00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 000000	0 00000	28, 695. 56000	0. 000000	0. 000000	203 00
203.00	Cost to be allocated (per Wkst. B,	0.00000		7,740			203.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 000000	0. 000000	77.40000	0. 000000	0.000000	205.00
	111)	T	I	1	т I		I

ST ALLOCAT	cial Systems TION - STATISTICAL BASIS	HARRIS CO PSYCH			Peri od:	u of Form CMS-: Worksheet B-1	
					From 09/01/2014 To 08/31/2015	Date/Time Pre	
						1/28/2016 11: INTERNS &	28
						RESI DENTS	
	Cost Center Description	MEDI CAL	SOCI AL SERVI CE		NURSI NG SCHOOL		
		RECORDS & LI BRARY	(TIME	ANESTHETI STS (ASSI GNED	(ASSI GNED	Y & FRINGES (TIME SPENT)	
		(GROSS	SPENT)	TIME)	TI ME)	(TIME SPENT)	
		CHARGES)					
GENER	AL SERVICE COST CENTERS	16.00	17.00	19.00	20.00	21.00	+
	NEW CAP REL COSTS-BLDG & FIXT						1
	NEW CAP REL COSTS-MVBLE EQUIP						
	EMPLOYEE BENEFITS DEPARTMENT						
	ADMI NI STRATI VE & GENERAL						
1	MAINTENANCE & REPAIRS OPERATION OF PLANT						
	LAUNDRY & LINEN SERVICE						
00900	HOUSEKEEPING						
	DIETARY						1
	CAFETERIA						1
	MAI NTENANCE OF PERSONNEL NURSI NG ADMI NI STRATI ON						
	CENTRAL SERVICES & SUPPLY						1
00 01500	PHARMACY						1
	MEDICAL RECORDS & LIBRARY	72, 398, 596					1
	SOCI AL SERVI CE NONPHYSI CI AN ANESTHETI STS		0		0		1
	NURSING SCHOOL				0		2
	I &R SERVICES-SALARY & FRINGES APPRVD	C	0		Ū	100	
	I&R SERVICES-OTHER PRGM COSTS APPRVD	C	-				2
	PARAMED ED PRGM	C	0				2
	I ENT ROUTI NE SERVI CE COST CENTERS ADULTS & PEDI ATRI CS	65, 323, 790	C		0 0	100	3
	INTENSIVE CARE UNIT	05, 525, 770			0 0	0	
	NURSING FACILITY	C			0 0	0	
	LARY SERVICE COST CENTERS		1	1	-		
	RADI OLOGY-DI AGNOSTI C	C			0 0	0	
	ANCI LLARY SERVI CES RADI OI SOTOPE	559, 470			0 0	0	
	CT SCAN				0 0	0	-
	MAGNETIC RESONANCE IMAGING (MRI)	C	C)	0 0	0	
	CARDI AC CATHETERI ZATI ON	C	C		0 0	0	5
		C	0		0 0	0	6
	BLOOD LABORATORY RESPI RATORY THERAPY					0	6
	PHYSI CAL THERAPY				0 0	0	
	OCCUPATIONAL THERAPY	C	C		0 0	0	
	THERAPY SERVICES	2, 658, 485			0 0	0	-
	ELECTROSHOCK THERAPY	138, 550	0		0 0	0	
	SPEECH PATHOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0 0	0	-
	IMPL. DEV. CHARGED TO PATIENTS				0 0	0	
	DRUGS CHARGED TO PATIENTS	3, 718, 301			0 0	0	
	RENAL DI ALYSI S	C	C		0 0	0	
	ASC (NON-DI STINCT PART)	C	0		0 0	0	
	PARTIAL HOSPITALIZATION TIENT SERVICE COST CENTERS	C	0	1	0 0	0	7
	RURAL HEALTH CLINIC	C	C		0 0	0	8
	FEDERALLY QUALIFIED HEALTH CENTER	C	0		0 0	0	
00 09000	CLINIC	C	C		0 0	0	
	EMERGENCY	C	O		0 0	0	
	OBSERVATION BEDS (NON-DISTINCT PART) AL PURPOSE COST CENTERS			1			9
. 00	SUBTOTALS (SUM OF LINES 1-117)	72, 398, 596	C		0 0	100	111
NONRE	MBURSABLE COST CENTERS		· · ·				
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0		0 0		19
	RESEARCH				0 0		19
. 01 19101	PROBATE COURT Cross Foot Adjustments				0	0	19 20
. 00	Negative Cost Centers						20
. 00	Cost to be allocated (per Wkst. B,	589, 480	C		o o	473, 508	
	Part I)						
3. 00	Unit cost multiplier (Wkst. B, Part I)	0.008142		0.00000	0 0. 000000	4, 735. 080000	
. 00	Cost to be allocated (per Wkst. B,	4,230	0		0 0	505	20
. 00	Part II) Unit cost multiplier (Wkst. B, Part	0. 000058	0. 000000	0. 00000	0.000000	5.050000	20
	John Coscinui (IPITEL (WKSL. D, Pail	0.000058	0.00000	0.00000	0.00000	5.050000	120

	ancial Systems ATION - STATISTICAL BASIS	HARRIS CO PSYCH		CCN: 454076	In Lie Period:	u of Form CMS-: Worksheet B-1	
CUST ALLUC	ATTON - STATISTICAL DASIS		Provider	CCN. 454076	From 09/01/2014 To 08/31/2015	Date/Time Pre	
		INTERNS &				1/28/2016 11:	
	Cost Center Description	RESIDENTS SERVICES-OTHER PRGM COSTS (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)				
CEN	ERAL SERVICE COST CENTERS	22.00	23.00				
1.00 0010 2.00 0020 4.00 0040 5.00 0050 6.00 0060 7.00 0070 8.00 0080 9.00 0090 10.00 0100 11.00 0110 12.00 0120	DO NEW CAP REL COSTS-BLDG & FIXT DO NEW CAP REL COSTS-MVBLE EQUIP DO EMPLOYEE BENEFITS DEPARTMENT DO ADMI NI STRATI VE & GENERAL DO MAI NTENANCE & REPAI RS DO DOPERATION OF PLANT DO LAUNDRY & LINEN SERVICE DO DO IETARY DO CAFETERIA DO MAI NTENANCE OF PERSONNEL DO NURSI NG ADMI NI STRATI ON						1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
14.00 0140	DO CENTRAL SERVI CES & SUPPLY						14.00
	DO PHARMACY DO MEDI CAL RECORDS & LI BRARY						15.00 16.00
19.00 0190	DO SOCIAL SERVICE DO NONPHYSICIAN ANESTHETISTS DO NURSING SCHOOL						17.00 19.00 20.00
21.00 0210	DO I &R SERVICES-SALARY & FRINGES APPRVD	100					21.00
	DO I&R SERVICES-OTHER PRGM COSTS APPRVD DO PARAMED ED PRGM	100	0				22.00 23.00
	ATIENT ROUTINE SERVICE COST CENTERS	100	0				30.00
	DO I NTENSI VE CARE UNI T	0	0				31.00
	DO NURSING FACILITY LLARY SERVICE COST CENTERS	0	0				45.00
	DO RADI OLOGY-DI AGNOSTI C	0	0				54.00
54.01 0540	D1 ANCI LLARY SERVI CES	0	0				54.01
	DO RADI OI SOTOPE DO CT SCAN	0	0				56.00 57.00
58.00 0580	DO MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
	DO CARDI AC CATHETERI ZATI ON	0	0				59.00
	DO LABORATORY D1 BLOOD LABORATORY	0	0				60.00 60.01
65.00 0650	DO RESPI RATORY THERAPY	0	0				65.00
	00 PHYSI CAL THERAPY 00 OCCUPATI ONAL THERAPY	0	0				66.00 67.00
	DI THERAPY SERVICES	0	0				67.00
	20 ELECTROSHOCK THERAPY	0	0				67.02
	DO SPEECH PATHOLOGY DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				68.00 71.00
	DO I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	DO DRUGS CHARGED TO PATIENTS	0	0				73.00
	DO RENAL DI ALYSI S DO ASC (NON-DI STI NCT PART)	0	0				74.00 75.00
76.00 030	20 PARTIAL HOSPITALIZATION	0	0				76.00
	PATIENT SERVICE COST CENTERS	0	0				88.00
89.00 0890	DO FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
		0	0				90.00
	00 EMERGENCY 00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				91.00 92.00
SPE	CLAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117) REIMBURSABLE COST CENTERS	100	0				118.00
	DO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
		0	0				191.00
200.00	01 PROBATE COURT Cross Foot Adjustments	0	0				191. 01 200. 00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 168, 077	0				202.00
203.00 204.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	11, 680. 770000 3, 012	0. 000000 0				203. 00 204. 00
205.00	Part II) Unit cost multiplier (Wkst. B, Part		0. 000000				205.00
203.00	II)	30. 120000	0.000000				203.00

	ncial Systems OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 454076	Peri od:	u of Form CMS- Worksheet C	2332-10
COMIN OTATION			110VI dei	0011. 404070	From 09/01/2014		
					To 08/31/2015	Date/Time Pre	epared:
				20/111		1/28/2016 11:	28 am
	·			e XVIII	Hospi tal	PPS	
	Cast Contor Description	Total Cost	Therapy Limit	Total Costs	Costs RCE	Total Costs	
	Cost Center Description	Total Cost (from Wkst. B,	Adj.		Di sal l owance	TOTAL COSTS	
		Part I, col.	Auj.		DISALIOWALICE		
		26)					
		1.00	2.00	3.00	4.00	5.00	
	IENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	ADULTS & PEDIATRICS	39, 350, 226		39, 350, 2	26 0	39, 350, 226	30.00
	INTENSIVE CARE UNIT	07, 000, 220		37, 330, 2	20 0	0, 350, 220	1
	NURSING FACILITY	0			0 0	0	
	LARY SERVICE COST CENTERS	0	1		0 0	0	45.00
	RADI OLOGY-DI AGNOSTI C	0	1		0 0	0	54.00
	ANCI LLARY SERVICES	668, 265		668, 2		668, 265	
	RADI OI SOTOPE	000, 203		000, 2	0 0	000, 203	
	CT SCAN	0			0 0	0	
	MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	
	CARDIAC CATHETERIZATION	0			0 0	0	
	LABORATORY	0			0 0	0	
	BLOOD LABORATORY	0			0 0		
		0			0 0	Ű	00.01
		0			0 0	0	
	PHYSICAL THERAPY	0			0 0	0	00.00
	OCCUPATIONAL THERAPY	0	0	1 001 0	0 0	0	
	THERAPY SERVICES	4, 331, 078	0	4, 331, 0		4, 331, 078	
	ELECTROSHOCK THERAPY	241, 321	0	241, 3	21 0	241, 321	
	SPEECH PATHOLOGY	0	0)	0 0	0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	
	IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	
	DRUGS CHARGED TO PATIENTS	2, 486, 163		2, 486, 1	63 0	2, 486, 163	
	RENAL DIALYSIS	0			0 0	0	
	ASC (NON-DISTINCT PART)	0			0 0	0	
	PARTIAL HOSPITALIZATION	0			0 0	0	76.00
	TIENT SERVICE COST CENTERS	-1	1		1		
	RURAL HEALTH CLINIC	0			0 0	0	
	FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
		0			0 0	0	
	EMERGENCY	0			0 0	0	1 / 11 00
	OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
200.00	Subtotal (see instructions)	47,077,053	0	47, 077, 0	53 0	,,	
201.00	Less Observation Beds	0			0	0	
202.00	Total (see instructions)	47,077,053	0	47,077,0	53 0	47,077,053	1202 00

Health Financial Systems	ARRIS CO PSYCH	ATRIC CENTER		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			CCN: 454076	Period: From 09/01/2014 To 08/31/2015	Worksheet C Part I Date/Time Pre 1/28/2016 11:	epared: 28 am
			e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	65, 323, 790		65, 323, 7	90		30.00
31.00 03100 INTENSIVE CARE UNIT	0			0		31.00
45.00 04500 NURSING FACILITY	0			0		45.00
ANCI LLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0. 000000		
54. 01 05401 ANCI LLARY SERVI CES	559, 470	0	559, 4		0.00000	
56. 00 05600 RADI OI SOTOPE	0	0		0 0. 000000		
57.00 05700 CT SCAN	0	0		0 0. 000000		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0. 000000	0.00000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0. 000000		
60. 00 06000 LABORATORY	0	0		0 0. 000000	0.00000	
60.01 06001 BLOOD LABORATORY	0	0		0 0.000000	0.00000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0. 000000		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0. 000000	0.00000	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0. 000000		
67. 01 06701 THERAPY SERVICES	2, 658, 485	0			0.00000	
67.02 03320 ELECTROSHOCK THERAPY	27, 200	111, 350	138, 5		0. 000000	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0.000000	0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0.000000		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0. 000000		
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 718, 301	0	3, 718, 30		0.00000	
74.00 07400 RENAL DIALYSIS	0	0		0 0. 000000	0. 000000	
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0. 000000		
76.00 03020 PARTI AL HOSPI TALI ZATI ON	0	0		0 0.000000	0.00000	76.00
OUTPATIENT SERVICE COST CENTERS	I					
88.00 08800 RURAL HEALTH CLINIC	0	0		0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.00
90. 00 09000 CLINIC	0	0		0 0.000000		
91. 00 09100 EMERGENCY	0	0		0 0. 000000		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0.000000	0.00000	
200.00 Subtotal (see instructions)	72, 287, 246	111, 350	72, 398, 59	96		200. 00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	72, 287, 246	111, 350	72, 398, 59	96		202.00

ealth Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	HARRIS CO PSYCHIAT	Provider CCN: 454076	Peri od:	u of Form CMS-255 Worksheet C
OWFUTATION OF RATIO OF COSTS TO CHARGES		FIOVIDEI CCN. 454070	From 09/01/2014	Part I
			To 08/31/2015	Date/Time Prepar
				1/28/2016 11:28
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
0. 00 03000 ADULTS & PEDI ATRI CS				30
1. 00 03100 I NTENSI VE CARE UNI T				31
5. 00 04500 NURSING FACILITY				45
ANCI LLARY SERVICE COST CENTERS				
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54
4. 01 05401 ANCI LLARY SERVICES	1. 194461			54
6. 00 05600 RADI OI SOTOPE	0.000000			56
7. 00 05700 CT SCAN	0.000000			57
8.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0.000000			58
9. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000			59
0. 00 06000 LABORATORY	0. 000000			60
0. 01 06001 BLOOD LABORATORY	0.000000			60
5. 00 06500 RESPI RATORY THERAPY	0.000000			65
6. 00 06600 PHYSI CAL THERAPY	0.000000			66
7.00 06700 OCCUPATI ONAL THERAPY	0.000000			67
7. 01 06701 THERAPY SERVICES	1. 629153			67
7.02 03320 ELECTROSHOCK THERAPY	1. 741761			67
8.00 06800 SPEECH PATHOLOGY	0. 000000			68
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 668629			73
4.00 07400 RENAL DIALYSIS	0. 000000			74
5.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75
6. 00 03020 PARTIAL HOSPITALIZATION	0.000000			76
OUTPATIENT SERVICE COST CENTERS				
8.00 08800 RURAL HEALTH CLINIC				88
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89
0. 00 09000 CLINIC	0. 000000			90
1.00 09100 EMERGENCY	0. 000000			91
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92
00.00 Subtotal (see instructions)				200
01.00 Less Observation Beds				201
02.00 Total (see instructions)				202

COMPUTATION OF RATIO	TEMS OF COSTS TO CHARGES		Provi der	CCN: 454076	Peri od:	Worksheet C	2552-10
			110VI dei	CON: 454070	From 09/01/2014	Part I	
					To 08/31/2015	Date/Time Pre	epared:
						1/28/2016 11:	28 am
			1 1	le XIX	Hospi tal	Cost	
Cost Con	ter Description	Total Cost	Therapy Limit	Total Costs	Costs RCE	Total Costs	
COST CEN	ter bescription	(from Wkst. B,	Adj.		Di sal l owance	TOTAL COSTS	
		Part I, col.	Auj .		DI Sal I Owalice		
		26)					
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUT	INE SERVICE COST CENTERS	1.00	2.00	5.00	4.00	3.00	
30.00 03000 ADULTS &		39, 350, 226		39, 350, 2	26 0	39, 350, 226	30.00
31. 00 03100 I NTENSI V		0,,000,220		0,,000,2	0 0	0,,000,220	1
45.00 04500 NURSI NG		0			0 0	0	
	I CE COST CENTERS				0 0		
54.00 05400 RADI OLOG		0			0 0	0	54.00
54.01 05401 ANCI LLAR		668, 265		668, 20	55 0	668, 265	54.01
56.00 05600 RADI 0I SO		0			0 0	0	
57.00 05700 CT SCAN		0			0 0	0	
	RESONANCE IMAGING (MRI)	0			0 0	0	
	CATHETERI ZATI ON	0			0 0	0	
60.00 06000 LABORATO		0			0 0	0	
60.01 06001 BLOOD LA		0			0 0	0	
65.00 06500 RESPI RAT		0	c c		0 0	0	
66.00 06600 PHYSI CAL		0	0		0 0	0	
67.00 06700 0CCUPATI		0	0		0 0	0	
67.01 06701 THERAPY		4, 331, 078		4, 331, 0	78 0	4, 331, 078	
67.02 03320 ELECTROS		241, 321		241, 3		241, 321	
68.00 06800 SPEECH P		2,02.		21170	0 0	0	
	SUPPLIES CHARGED TO PATIENTS	0	-		0 0	0	
	V. CHARGED TO PATIENTS	0			0 0	0	
	ARGED TO PATIENTS	2, 486, 163		2, 486, 10	53 0	2, 486, 163	
74.00 07400 RENAL DI		2, 100, 100		2,100,11		2, 100, 100	
	-DISTINCT PART)	0			0 0	0	
	HOSPI TALI ZATI ON	0			0 0	0	
	VICE COST CENTERS		1	1	0 0		
88.00 08800 RURAL HE		0			0 0	0	88.00
	Y QUALIFIED HEALTH CENTER	0			0 0	0	89.00
90.00 09000 CLINIC		0			0 0	0	
91.00 09100 EMERGENC	Y	0			0 0	0	
	ION BEDS (NON-DISTINCT PART)	0			0	0	
	(see instructions)	47, 077, 053	c c	47,077,0	53 0	47,077,053	
	ervation Beds	0	-		0	0	

Health Financial Systems	HARRIS CO PSYCHI	ATRIC CENTER		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES				Period: From 09/01/2014 To 08/31/2015	1/28/2016 11:	epared: 28 am
			le XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	65, 323, 790		65, 323, 79	90		30.00
31.00 03100 INTENSIVE CARE UNIT	0			0		31.00
45.00 04500 NURSING FACILITY	0			0		45.00
ANCI LLARY SERVI CE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			_		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0. 000000		
54. 01 05401 ANCI LLARY SERVI CES	559, 470	0	559, 47		0.00000	
56. 00 05600 RADI OI SOTOPE	0	0		0 0. 000000	0.00000	
57.00 05700 CT SCAN	0	0		0 0. 000000	0.00000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0. 000000	0.00000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0. 000000	0.00000	
60. 00 06000 LABORATORY	0	0		0 0. 000000	0.00000	
60.01 06001 BLOOD LABORATORY	0	0		0 0.000000	0.00000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0. 000000	0.00000	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0. 000000	0.00000	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0. 000000	0.00000	1
67. 01 06701 THERAPY SERVICES	2, 658, 485	0	2, 658, 48		0.00000	
67.02 03320 ELECTROSHOCK THERAPY	27, 200	111, 350	138, 55		0.00000	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0.000000	0.00000	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0.000000	0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0.000000	0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 718, 301	0	3, 718, 30		0.00000	
74.00 07400 RENAL DIALYSIS	0	0		0 0.000000	0.00000	
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0.000000	0.00000	
76. 00 03020 PARTI AL HOSPI TALI ZATI ON	0	0		0 0.000000	0.00000	76.00
OUTPATIENT SERVICE COST CENTERS	1					
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0.000000	0.00000	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.000000	0.00000	
90. 00 09000 CLINIC	0	0		0 0.000000	0.00000	
91.00 09100 EMERGENCY	0	0		0 0.00000	0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0.000000	0.00000	
200.00 Subtotal (see instructions)	72, 287, 246	111, 350	72, 398, 59	26		200.00
201.00 Less Observation Beds			70			201.00
202.00 Total (see instructions)	72, 287, 246	111, 350	72, 398, 59	76		202.00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 454076	Period: From 09/01/2014 To 08/31/2015	Worksheet C Part I Date/Time Prepar 1/28/2016 11:28
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
D. 00 03000 ADULTS & PEDIATRICS				30
1.00 03100 INTENSIVE CARE UNIT				3
5.00 04500 NURSING FACILITY				4
ANCI LLARY SERVI CE COST CENTERS				
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54
4. 01 05401 ANCI LLARY SERVI CES	0. 000000			54
6. 00 05600 RADI OI SOTOPE	0. 000000			5
7.00 05700 CT SCAN	0. 000000			5
3.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58
9. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59
0. 00 06000 LABORATORY	0. 000000			60
D. 01 06001 BLOOD LABORATORY	0. 000000			6
5. 00 06500 RESPI RATORY THERAPY	0. 000000			6
5. 00 06600 PHYSI CAL THERAPY	0. 000000			6
7.00 06700 OCCUPATI ONAL THERAPY	0. 000000			6
7. 01 06701 THERAPY SERVICES	0. 000000			6
7.02 03320 ELECTROSHOCK THERAPY	0. 000000			6
3. 00 06800 SPEECH PATHOLOGY	0. 000000			6
I. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			7
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			7:
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			7
4. 00 07400 RENAL DIALYSIS	0. 000000			7
5.00 07500 ASC (NON-DISTINCT PART)	0. 000000			7
5. 00 03020 PARTIAL HOSPITALIZATION	0. 000000			7
OUTPATIENT SERVICE COST CENTERS				
3. 00 08800 RURAL HEALTH CLINIC	0. 000000			8
0.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			8
D. 00 09000 CLINIC	0. 000000			90
. 00 09100 EMERGENCY	0. 000000			9
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			93
00.00 Subtotal (see instructions)				20
01.00 Less Observation Beds				20
D2.00 Total (see instructions)				202

Health Financial Systems	HARRIS CO PSYCH	IATRIC CENTER		In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provi der	CCN: 454076	Period: From 09/01/2014 To 08/31/2015		
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Total Cost	Capital Cost	Operating Cos	st Capital	Operating Cost	
	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	al Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			•			
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 05401 ANCI LLARY SERVI CES	668, 265	1, 302	666, 96	53 76	66, 696	54.01
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60.01 06001 BLOOD LABORATORY	0	l o		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
67. 01 06701 THERAPY SERVICES	4, 331, 078	26, 556	4, 304, 52	1, 540	430, 452	67.01
67.02 03320 ELECTROSHOCK THERAPY	241, 321	3, 705			23, 762	67.02
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 486, 163	5, 491	2, 480, 67	318	248, 067	73.00
74.00 07400 RENAL DIALYSIS	0	0	,,	0 0	0	
75.00 07500 ASC (NON-DI STINCT PART)	0	0		0 0	0	75.00
76.00 03020 PARTI AL HOSPI TALI ZATI ON	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS				-		
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
200.00 Subtotal (sum of lines 50 thru 199)	7, 726, 827	37, 054	7, 689, 77	2, 149	-	
201.00 Less Observation Beds	0	0	, ,	0 0		201.00
202.00 Total (line 200 minus line 201)	7, 726, 827	37,054	7, 689, 77	2, 149		

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Port of cost Port of cost Port of cost Port of cost For mode of cost Port of cost For mode of cost Port of cost <th>Health Financial Systems</th> <th>HARRIS CO PSYCH</th> <th>IATRIC CENTER</th> <th></th> <th>In Lie</th> <th>u of Form CMS-</th> <th>2552-10</th>	Health Financial Systems	HARRIS CO PSYCH	IATRIC CENTER		In Lie	u of Form CMS-	2552-10
Cost Center Description Cost Net of Cost Net of Reduction Total Charges Quiptal and Deperating Cost Part 1, column Ratio (col. 6 Outpatient Ratio (col. 6 ANCILLARY SERVICE COST CENTERS 6.00 7.00 8.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0.000000 56.00 05500 CR DAIOISTOPE 0 0 0.000000 58.00 05500 CR DAIOISTOPE 0 0 0.000000 59.00 05800 CARDIAC CATHETERIZATION 0 0 0.000000 60.01 0.000000 0 0.000000 66.00 60.00 06000 LABORATORY 0 0 0.000000 66.00 61.01 0.000000 66.00 0.000000 66.00 67.00 62.00 06000 PHYSICAL HERAPY 0 0 0.000000 67.00	CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA			CCN: 454076	Period: From 09/01/2014	Worksheet C Part II Date/Time Pre	epared:
ANCI LLARY SERVICE COST CENTERS Capit all and Worksheet C, Cost to Charge Operating Cost to Col 6 Anci LLARY SERVICE COST CENTERS 54.00 05400 RADI 0LOGY-DI AGNOSTI C 0 0 0.000000 54.00 54.10 05400 RADI 0LOGY-DI AGNOSTI C 0 0 0.000000 54.00 54.01 05400 RADI 0LOGY-DI AGNOSTI C 0 0 0.000000 54.01 54.01 05401 ANCI LLARY SERVICES 601,493 559,470 1.075112 54.01 57.00 05700 CT SCAN 0 0 0.000000 58.00 58.00 05800 MGRETI C RESONANCE I MAGI NG (MRI) 0 0 0.000000 58.00 59.00 05900 CARDI A CATHETERI ZATI ON 0 0 0.000000 60.01 60.00 06000 LABORATORY 0 0 0.000000 66.00 61.00 06000 RESPI RATORY THERAPY 0 0 0.000000 66.00 62.00 06000 RESPI RATORY THERAPY 0 0 0.000000 67.00 61.00 06000 RESPI RATORY THERAPY 0			Tit	le XIX	Hospi tal	Cost	
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Reduction 8) / col. 7) 6.00 7.00 8.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0.000000 54.01 05400 RADIOLOGY-DIAGNOSTIC 0 0 0.000000 54.01 05400 RADIOLOGY-DIAGNOSTIC 0 0 0.000000 54.01 05600 RADIOLOGY-DIAGNOSTIC 0 0 0.000000 55.00 05600 RARIETIC RESONANCE IMAGING (MRI) 0 0 0.000000 59.00 05600 CARDIAC CATHETERIZATION 0 0 0.000000 60.00 06000 LABORATORY 0 0 0.000000 60.00 61.00 06500 RSPIRATORY THERAPY 0 0 0.000000 65.00 65.00 06500 RSPIRATORY THERAPY 0 0 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0.000000 67.00 67.01 06701 ROMONCONCOUPATIONAL THERAPY		Capital and	(Worksheet C,	Cost to Char	ge		
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72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2,237,778 3,718,301 0.601828 73.00 74.00 07400 RENAL DIALYSIS 0 0 0.000000 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 75.00 76.00 03020 PARTIAL HOSPITALIZATION 0 0 0.000000 76.00 0UTPATIENT SERVICE COST CENTERS 0 0 0.000000 88.00 88.00 88.00 08900 RURAL HEALTH CLINIC 0 0 0.000000 89.00 90.00 09000 CLINIC 0 0 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0.000000 90.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0.000000 92.00 200.00 Subtotal (sum of Lines 50 thru 199) 6, 955, 701 7, 074, 806 200.00 201.00 Less Observation Beds 0 0 0<	68.00 06800 SPEECH PATHOLOGY	0	0	0.0000	00		68.00
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74. 00 07400 RENAL DI ALYSI S 0 0 0.000000 74. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 75. 00 76. 00 03020 PARTI AL HOSPI TALIZATI ON 0 0 0.000000 76. 00 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 88. 00 88. 00 88. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0.000000 89. 00 90. 00 09000 CLI NI C 0 0 0.000000 90. 00 91. 00 09100 DEREGENCY 0 0 0.000000 91. 00 92. 00 092000 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0.000000 92. 00 92. 00 92. 00 200. 00 200. 00 200. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 <	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.0000	00		72.00
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76.00 03020 PARTIAL HOSPITALIZATION 0 0 0.000000 76.00 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 88.00 88.00 88.00 0.000000 88.00 89.00 0.000000 89.00 90.00 0.000000 90.00 90.00 90.00 90.00 90.00 91.00 0.000000 91.00 91.00 92.00 0.000000 92.00 92.00 0.000000 92.00 200.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 0 0 0 0 201.00	74.00 07400 RENAL DIALYSIS	0	0	0.0000	00		74.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 89.00 90.00 09000 CLINIC 0 0 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0.000000 91.00 92.00 09SERVATI ON BEDS (NON-DI STINCT PART) 0 0 0.000000 92.00 200.00 Subtotal (sum of lines 50 thru 199) 6, 955, 701 7, 074, 806 200.00 201.00	75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.0000	00		75.00
88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 89.00 90.00 09000 CLINIC 0 0 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0.000000 91.00 92.00 09SERVATION BEDS (NON-DISTINCT PART) 0 0 0.000000 92.00 200.00 Subtotal (sum of lines 50 thru 199) 6,955,701 7,074,806 200.00 201.00	76.00 03020 PARTI AL HOSPI TALI ZATI ON	0	0	0.0000	00		76.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 89.00 89.00 90.00 91.00 92.00	OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC 00 0 0.00000 90.00 90.00 91.00 09100 EMERGENCY 0 0 0.000000 91.00 91.00 91.00 91.00 92.00 200.000 0.000000 92.00 92.00 92.00 92.00 200.00 200.00 200.00 200.00 201.00	88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	00		88.00
91.00 09100 EMERGENCY 0 0 0.000000 91.00 92.00 92.00 0.000000 92.00 <	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000	00		89.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0.000000 92.00	90. 00 09000 CLINIC	0	0	0.0000	00		90.00
200.00 Subtotal (sum of lines 50 thru 199) 6,955,701 7,074,806 200.00 201.00 201.00	91.00 09100 EMERGENCY	0	0	0.0000	00		91.00
201.00 Less Observation Beds 0 0 0 201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.0000	00		92.00
	200.00 Subtotal (sum of lines 50 thru 199)	6, 955, 701	7, 074, 806				200. 00
202.00 Total (line 200 minus line 201) 6,955,701 7,074,806 202.00	201.00 Less Observation Beds	0	0				201.00
	202.00 Total (line 200 minus line 201)	6, 955, 701	7, 074, 806				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Provider CCN: 454076 Period: From 09/01/2014 TO 09/01/2	Health Financial Systems	HARRIS CO PSYCH	IATRIC CENTER		In Lie	eu of Form CMS-:	2552-10
Cost Center Description Total Cost (Wkst. B, Part) 1. col. 26) Capital Cost (and color) (Col. 2) Capital Reduction (Col. 2) Operating Cost Reduction (Col. 2) Capital Reduction 4NCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 6 0 0 0 0 54.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 6 0 0 0 0 0 56.00 56.00 05000 RADIOLOGY-DIAGNOSTIC 6 0		ATIOS NET OF	Provi der		From 09/01/2014	Part II Date/Time Pre	pared: 28 am
ANCILLARY SERVICE COST CENTERS (Wkst. B, Part (Wkst. B, PartNet of Capital Local 2) Reduction Amount 4.00 05400 RADIOLOGY-DI AKNOSTIC 0 0 0 0 5.00 54.00 05400 RADIOLOGY-DI AKNOSTIC 668.265 1.302 666.963 76 66.6963 76 66.6963 76 66.6963 76 66.6963 58.00 57.00 05700 CT SCAN 0 0 0 0 0 58.00 59.00 6600 RESPIRATORY 0 0 0 59.00 660.01 66			Ti	tle V	Hospi tal		
ANCILLARY SERVICE COST CENTERS (Wkst. B, Part (Wkst. B, PartNet of Capital Local 2) Reduction Amount 4.00 05400 RADIOLOGY-DI AKNOSTIC 0 0 0 0 5.00 54.00 05400 RADIOLOGY-DI AKNOSTIC 668.265 1.302 666.963 76 66.6963 76 66.6963 76 66.6963 76 66.6963 58.00 57.00 05700 CT SCAN 0 0 0 0 0 58.00 59.00 6600 RESPIRATORY 0 0 0 59.00 660.01 66	Cost Center Description	Total Cost	Capital Cost	Operating Cos	st Capital	Operating Cost	
ANCI LLARY SERVICE COST CENTERS 54.00 05400 AA010 LOGY-DIAGNOSTIC 0 0 0 0 0 0 0 54.00 54.10 05400 RADIO LOGY-DIAGNOSTIC 0		(Wkst. B, Part	(Wkst. B, Part	Net of Capita	al Reduction	Reduction	
I.00 2.00 3.00 4.00 5.00 54.00 05400 RADI LLARY SERVICE COST CENTERS 54.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 57.00 57.00 57.00 57.00 0 0 0 0 0 58.00 58.00 58.00 59.00 60.00 0		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
ANCILLARY SERVICE COST CENTERS 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 0 54.00 54.01 05400 RADIOLOGY-DIAGNOSTIC 668,265 1,302 666,963 76 66,696 54.01 55.00 05500 CTSCAN 0 0 0 0 0 55.00 59.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 0 0 58.00 59.00 05900 CARDI AC CATHETERIZATION 0				col. 2)			
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 54.00 54.01 05401 ANCI LLARY SERVI CES 668, 265 1, 302 666, 963 76 66, 696 54.00 55.00 05500 CT SCAN 0<		1.00	2.00	3.00	4.00	5.00	
54.01 05401 ANCI LLARY SERVI CES 668, 265 1, 302 666, 963 76 66, 696 54.01 56.00 0500 CT SCAN 0 0 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 0 0 0 56.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 <td< td=""><td>ANCI LLARY SERVI CE COST CENTERS</td><td></td><td></td><td></td><td></td><td></td><td></td></td<>	ANCI LLARY SERVI CE COST CENTERS						
54.01 05401 ANCI LLARY SERVI CES 668, 265 1, 302 666, 963 76 66, 696 54.01 56.00 0500 CT SCAN 0 0 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 0 0 0 56.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 <td< td=""><td>54.00 05400 RADI OLOGY-DI AGNOSTI C</td><td>0</td><td>C</td><td></td><td>0 0</td><td>0</td><td>54.00</td></td<>	54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
56.00 05600 RADIOLSTOPE 0 0 0 0 0 56.00 57.00 05700 CTSCAN 0 0 0 0 0 0 57.00 0 57.00 0 <td>54. 01 05401 ANCI LLARY SERVI CES</td> <td>668, 265</td> <td>1, 302</td> <td>666.96</td> <td>53 76</td> <td>66, 696</td> <td>54.01</td>	54. 01 05401 ANCI LLARY SERVI CES	668, 265	1, 302	666.96	53 76	66, 696	54.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 0 58.00 59.00 CARDI AC CATHETERI ZATION 0 0 0 0 0 59.00 60.00 CABORATORY 0 0 0 0 0 60.01 60.01 BLOOD LABORATORY 0 0 0 0 60.01 65.00 C6500 RESPI RATORY THERAPY 0 0 0 66.00 66.00 OCCUPATI ONAL THERAPY 0 0 0 0 67.00 67.00 OC10 OCCUPATI ONAL THERAPY 0 0 0 0 67.01 67.01 IHERAPY SERVICES 4, 331, 078 26, 556 4, 304, 522 1, 540 430, 452 67.01 67.00 OR600 SPECH PATHOLOGY 0 0 0 0 72.00 0 0 0 73.00 71.00 OT300 DRUGS CHARGED TO PATI ENTS 2, 486, 163 5, 491		0	C		0 0		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 0 58.00 59.00 CARDI AC CATHETERI ZATION 0 0 0 0 0 59.00 60.00 CABORATORY 0 0 0 0 0 60.01 60.01 BLOOD LABORATORY 0 0 0 0 60.01 65.00 C6500 RESPI RATORY THERAPY 0 0 0 66.00 66.00 OCCUPATI ONAL THERAPY 0 0 0 0 67.00 67.00 OC10 OCCUPATI ONAL THERAPY 0 0 0 0 67.01 67.01 IHERAPY SERVICES 4, 331, 078 26, 556 4, 304, 522 1, 540 430, 452 67.01 67.00 OR600 SPECH PATHOLOGY 0 0 0 0 72.00 0 0 0 73.00 71.00 OT300 DRUGS CHARGED TO PATI ENTS 2, 486, 163 5, 491		0	0		0 0	-	
59.00 05900 CARDIAC CATHETERIZATION 0 <t< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td></td></t<>		0	0		0 0	0	
60.00 C6000 LABORATORY 0		0	0		0 0	0	
60.01 06001 BLOOD LABORATORY 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td></td>		0	0		0 0	0	
65.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 0 66.00 67.01 06701 THERAPY SERVI CES 4, 331, 078 26, 556 4, 304, 522 1, 540 430, 452 67. 01 67.02 03320 ELECTROSHOCK THERAPY 241, 321 3, 705 237, 616 215 23, 762 67. 02 68.00 06800 SPECH PATHOLOGY 0 0 0 0 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 71. 00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 72. 00 73.00 07300 DRUGS CHARGED TO PATI ENTS 2, 486, 163 5, 491 2, 480, 672 318 248, 067 73. 00 74.00 07400 RENAL DI ALSY IS 0 0 0 0 0 0 0 0		0	0		0 0	-	
66.00 06600 PHYSI CAL THERAPY 0<		0	0			-	1
67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 67.00 67.01 06701 THERAPY SERVI CES 4, 331, 078 26, 556 4, 304, 522 1, 540 430, 452 67.01 67.02 03320 ELECTROSHOCK THERAPY 241, 321 3, 705 237, 616 215 23, 762 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 2, 486, 163 5, 491 2, 480, 672 318 248, 067 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 74.00 74.00 75.00 0 0 0 74.00 75.00 03202 PARTI AL HOSPI TALI ZATI ON 0 0 0 0 0 0 76.00 <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td>		0	0			0	
67.01 06701 THERAPY SERVICES 4, 331,078 26,556 4, 304,522 1,540 430,452 67.01 67.02 0320 ELECTROSHOCK THERAPY 241,321 3,705 237,616 215 23,762 67.02 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 70.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 73.00 74.00 0 0 0 73.00 73.00 74.00 73.00 74.00 74.00 73.00 74.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 76.00 0 0 0 0 75.00 76.00 0800 RURAL HEALTH CLINIC 0 0 0 0 0 0 88.00 89.00 08000 RURAL HEALTH CLINIC 0 0 0 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		0					
67. 02 03320 ELECTROSHOCK THERAPY 241, 321 3, 705 237, 616 215 23, 762 67. 02 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68. 00 71. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 2, 486, 163 5, 491 2, 480, 672 318 248, 067 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 75. 00 76. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 76. 00 99. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00 89. 00 08800 RURAL HEALTH CLINIC 0 0		1 331 078	26 556	1 304 5	1 540	-	1
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 2, 486, 163 5, 491 2, 480, 672 318 248, 067 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 75.00 76.00 03020 PARTI AL HOSPI TALI ZATI ON 0 0 0 0 76.00 0017011 ENT SERVICE COST CENTERS 0 0 0 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 89.00 90.00 09000 CLINIC 0 0 0 0 0 90.00 91.00 0900							
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2,486,163 5,491 2,480,672 318 248,067 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 75.00 76.00 03020 PARTIAL HOSPI TALIZATION 0 0 0 0 0 76.00 0000 08300 RURAL HEALTH CLINIC 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 09100 EMERGENCY 0 0 0 0 0 90.00 91.00 09200 OB		241, 321	3, 703	237,0	0 213		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2,486,163 5,491 2,480,672 318 248,067 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75.00 76.00 03020 PARTIAL HOSPI TALIZATION 0<		0	0		0 0	-	
73.00 07300 DRUGS CHARGED TO PATIENTS 2,486,163 5,491 2,480,672 318 248,067 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 75.00 76.00 03020 PARTIAL HOSPI TALIZATION 0 0 0 0 0 76.00 0000000 PARTIAL HOSPI TALIZATION 0 0 0 0 0 76.00 000000000 PARTIAL HOSPI TALIZATION 0 0 0 0 0 73.00 78.00 03020 PARTIAL HOSPI TALIZATION 0 0 0 0 76.00 000000000000000000000000000000000000		0	0		0 0	-	
74.00 07400 RENAL DIALYSIS 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 75.00 76.00 03020 PARTI AL HOSPI TALI ZATI ON 0 0 0 0 0 76.00 88.00 88.00 89.00 89.00 89.00 89.00 89.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 91.00 91.00 <td></td> <td>2 404 142</td> <td>E 401</td> <td>2 400 47</td> <td>0 0 10 210</td> <td>-</td> <td>1</td>		2 404 142	E 401	2 400 47	0 0 10 210	-	1
75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 76.00 75.00 76.00 88.00 88.00 88.00 88.00 88.00 89.00 89.00 89.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00		2,480,103	5, 491	2,480,0	318		
76.00 03020 PARTIAL HOSPITALIZATION 0 0 0 0 0 0 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 88.00 88.00 88.00 08000 FUERALLY QUALIFIED HEALTH CLINIC 0 0 0 0 0 89.00 89.00 90.00 0 0 0 0 89.00 90.00 0 0 0 0 89.00 90.00 91.01 0 0 0 0 0 0 90.00 91.00 91.00 91.00 91.00 92.00 0 0 0 0 0 92.00 92.00 0 0 0 0 92.00 92.00 92.00 0 0 0 0 92.00 92.00 0 0 0 0 92.00 92.00 92.00 92.00 0 0 0 0 92.00 92.00 92.00		0	0		0 0	-	
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 09000 CLINIC 0 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 91.00 92.00 092000 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 200.00 Subtotal (sum of lines 50 thru 199) 7, 726, 827 37, 054 7, 689, 773 2, 149 768, 977 200.00 201.00 Less Observation Beds 0 0 0 0 0 0 201.00		0	0		0 0	-	
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 09000 CLINIC 0 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92.00 200.00 Subtotal (sum of lines 50 thru 199) 7, 726, 827 37, 054 7, 689, 773 2, 149 768, 977 200.00 201.00 Less Observation Beds 0 0 0 0 0 0 201.00		0	U		0 0	0	76.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 09000 CLINIC 0 0 0 0 90.00 90.00 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 200.00 Subtotal (sum of lines 50 thru 199) 7, 726, 827 37, 054 7, 689, 773 2, 149 768, 977 200.00 201.00 Less Observation Beds 0 0 0 0 0 0 0 201.00		1					
90.00 09000 CLINIC 00 00 00 90.00 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92.00 200.00 Subtotal (sum of lines 50 thru 199) 7, 726, 827 37, 054 7, 689, 773 2, 149 768, 977 200.00 201.00 Less Observation Beds 0 0 0 0 0 0 201.00		0	0		0 0	-	
91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92.00 200.00 Subtotal (sum of lines 50 thru 199) 7, 726, 827 37, 054 7, 689, 773 2, 149 768, 977 200.00 201.00 Less Observation Beds 0 0 0 0 0 0 0 0 201.00		0	0		0 0	-	
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00 200. 00 Subtotal (sum of lines 50 thru 199) 7, 726, 827 37, 054 7, 689, 773 2, 149 768, 977 200. 00 201. 00 Less Observation Beds 0 0 0 0 0 0 0 0 201. 00		0	0		0 0	-	
200.00 Subtotal (sum of lines 50 thru 199) 7, 726, 827 37, 054 7, 689, 773 2, 149 768, 977 200.00 201.00 Less Observation Beds 0 0 0 0 0 0 0 0 0 0 0 0 0 201.00		0	0		0 0	-	
201.00 Less Observation Beds 0 </td <td></td> <td>0</td> <td>C</td> <td></td> <td>0 0</td> <td>-</td> <td></td>		0	C		0 0	-	
		7, 726, 827	37, 054	7, 689, 7	2,149		
202.00 Iotal (line 200 minus line 201) 7,726,827 37,054 7,689,773 2,149 768,977 202.00		0	0		0 0		
	202.00 Total (line 200 minus line 201)	7, 726, 827	37, 054	7, 689, 7	2, 149	768, 977	202.00

Health Financial Systems	HARRIS CO PSYCH	II ATRI C CENTER		In Lie	eu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provi der	CCN: 454076	Period: From 09/01/2014 To 08/31/2015	Worksheet C Part II Date/Time Prepared: 1/28/2016 11:28 am
		Ti	tle V	Hospi tal	
Cost Center Description	Cost Net of	Total Charges	Outpati ent		
	Capital and	(Worksheet C,	Cost to Char	ge	
	Operating Cost	Part I, column	Ratio (col.	6	
	Reduction	8)	/ col. 7)		
	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS	1				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	-			54.00
54. 01 05401 ANCI LLARY SERVI CES	601, 493	559, 470	1. 0751	12	54.01
56. 00 05600 RADI OI SOTOPE	0	0	0.0000	00	56.00
57.00 05700 CT SCAN	0	0	0.0000		57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.0000	00	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.0000	00	59.00
60. 00 06000 LABORATORY	0	0	0.0000	00	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.0000	00	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0	0.0000	00	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0.0000	00	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C	0.0000	00	67.00
67. 01 06701 THERAPY SERVICES	3, 899, 086	2, 658, 485	1. 4666	57	67.01
67.02 03320 ELECTROSHOCK THERAPY	217, 344	138, 550	1. 5687	04	67.02
68.00 06800 SPEECH PATHOLOGY	0	0	0.0000	00	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.0000	00	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.0000	00	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 237, 778	3, 718, 301	0. 6018	28	73.00
74.00 07400 RENAL DIALYSIS	0	0	0.0000	00	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.0000	00	75.00
76.00 03020 PARTIAL HOSPITALIZATION	0	0	0.0000	00	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0	C	0.0000	00	88.00
89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0	0.0000	00	89.00
90. 00 09000 CLINIC	0	0	0.0000	00	90.00
91.00 09100 EMERGENCY	0	C	0.0000		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.0000	00	92.00
200.00 Subtotal (sum of lines 50 thru 199)	6, 955, 701	7, 074, 806			200.00
201.00 Less Observation Beds	0	C			201.00
202.00 Total (line 200 minus line 201)	6, 955, 701	7, 074, 806	,		202.00

lealth Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der	CCN: 454076 F	Peri od:	Worksheet D	
	00012			From 09/01/2014	Part I	
			-	To 08/31/2015		pared:
					1/28/2016 11:	28 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.		1	
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						4
30. 00 ADULTS & PEDIATRICS	259, 940	0	259, 940	0 81, 655		
31. 00 INTENSIVE CARE UNIT	0		(0 O	0.00	31.00
45.00 NURSING FACILITY	0		(o ol	0.00	45.00
200.00 Total (lines 30-199)	259, 940		259, 940	0 81, 655	('	200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
	/	(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						<u> </u>
30. 00 ADULTS & PEDIATRICS	3, 179	10, 109	/		I	30.0
31.00 INTENSIVE CARE UNIT	0	0	J		I	31.0
45.00 NURSING FACILITY	0	0	J		I	45.0
200.00 Total (lines 30-199)	3, 179	10, 109	/		I	200. 0

Health Financial Systems	HARRIS CO PSYCH	ILATRIC CENTER		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der	CCN: 454076	Peri od:	Worksheet D	
				From 09/01/2014		
				To 08/31/2015	Date/Time Pre 1/28/2016 11:	pared:
		Ti tl	e XVIII	Hospi tal	PPS	20 dili
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)		, í	
	26)	, i				
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	- F				F	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	, i i i i i i i i i i i i i i i i i i i	0.0000		-	0 11 00
54. 01 05401 ANCI LLARY SERVI CES	1, 302	559, 470				54.01
56. 00 05600 RADI OI SOTOPE	0	0	0.0000		0	56.00
57.00 05700 CT SCAN	0	C	0.0000		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	0.0000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C	0.0000	0 0	0	59.00
60. 00 06000 LABORATORY	0	C	0.0000	0 0	0	60.00
60.01 06001 BLOOD LABORATORY	0	C	0.0000	0 0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	C	0.0000		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C	0.0000	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0.0000	0 0	0	67.00
67. 01 06701 THERAPY SERVICES	26, 556	2, 658, 485	0.00998	39 82, 348	823	67.01
67.02 03320 ELECTROSHOCK THERAPY	3, 705	138, 550	0. 02674	41 5, 100	136	67.02
68.00 06800 SPEECH PATHOLOGY	0	0	0.0000	0 00	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.0000	0 00	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0.0000	0 00	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 491	3, 718, 301	0.0014	77 171, 207	253	73.00
74.00 07400 RENAL DIALYSIS	0	0	0.0000	0 00	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.0000	0 00	0	75.00
76.00 03020 PARTIAL HOSPITALIZATION	0	0	0.0000	0 00	0	76.00
OUTPATIENT SERVICE COST CENTERS	-					
88.00 08800 RURAL HEALTH CLINIC	0	C	0.0000	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000		0	
90. 00 09000 CLINIC	0	0	0.0000		0	90.00
91. 00 09100 EMERGENCY	0	0	0.0000	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.0000	0 0	0	
200.00 Total (lines 50-199)	37, 054	7, 074, 806		285, 070	1, 273	200. 00

Health Financial Systems	HARRIS CO PSYCH	HATRIC CENTER		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 09/01/2014 To 08/31/2015	Date/Time Pre 1/28/2016 11:	pared: 28 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0) (D	0 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0		D	0	0	31.00
45.00 04500 NURSING FACILITY	0		b	0	0	45.00
200.00 Total (lines 30-199)	0		b	0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpati ent		
'	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS			·			
30. 00 03000 ADULTS & PEDI ATRI CS	81,655	0.00	3, 17	9 0		1 30. 00
31. 00 03100 I NTENSI VE CARE UNI T	0	0.00		0 0		31.00
45. 00 04500 NURSING FACILITY		0.00		0 0		45.00
200.00 Total (lines 30-199)	81, 655		3, 17	9 0		200.00

Health Financial Systems	HARRIS CO PSYCH	IATRIC CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	6 Provi der	CCN: 454076	Peri od:	Worksheet D	
THROUGH COSTS				From 09/01/2014		
				To 08/31/2015	Date/Time Pre 1/28/2016 11:	pared: 28 am
		Ti tl	e XVIII	Hospi tal	PPS	20 am
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	Anestheti st	0		Medi cal	(sum of col 1	
	Cost			Educati on Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
54. 01 05401 ANCI LLARY SERVI CES	0	0		0 0	0	
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	
57.00 05700 CT SCAN	0	0		0 0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
60. 00 06000 LABORATORY	0	0		0 0	0	
60.01 06001 BLOOD LABORATORY	0	0		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
67. 01 06701 THERAPY SERVICES	0	0		0 0	0	67.01
67.02 03320 ELECTROSHOCK THERAPY	0	0		0 0	0	67.02
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0)	0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
76.00 03020 PARTI AL HOSPI TALI ZATI ON	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0)	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0)	0 0	0	89.00
90. 00 09000 CLINIC	0	0)	0 0	0	90.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
200.00 Total (lines 50-199)	0	0		0 0	0	200.00

	HARRIS CO PSYCH			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provi der		Period:	Worksheet D	
THROUGH COSTS				From 09/01/2014 To 08/31/2015		norod.
				To 08/31/2015	1/28/2016 11:	
		Ti tl	e XVIII	Hospi tal	PPS	20 411
Cost Center Description	Total	Total Charges			I npati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1	- 1	1	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0		0. 00000			54.00
54. 01 05401 ANCI LLARY SERVI CES	0	559, 470				54.01
56. 00 05600 RADI OI SOTOPE	0	0	0. 00000			56.00
57.00 05700 CT SCAN	0	0	0. 00000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0. 00000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000		0	59.00
60. 00 06000 LABORATORY	0	0	0. 00000		0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0. 00000			60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0	0. 00000	0.000000	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0. 00000	0.000000	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0. 00000	0.000000	0	67.00
67. 01 06701 THERAPY SERVICES	0	2, 658, 485	0. 00000	0.000000	82, 348	67.01
67.02 03320 ELECTROSHOCK THERAPY	0	138, 550	0. 00000	0.000000	5, 100	67.02
68.00 06800 SPEECH PATHOLOGY	0	0	0. 00000	0.000000	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0. 00000	0.000000	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 718, 301	0.00000	0.000000	171, 207	73.00
74.00 07400 RENAL DIALYSIS	0	0	0. 00000	0.000000	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0. 00000	0.000000	0	75.00
76.00 03020 PARTI AL HOSPI TALI ZATI ON	0	0	0. 00000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS			_			
88.00 08800 RURAL HEALTH CLINIC	0	0	0. 00000	0.000000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	0.000000	0	89.00
90. 00 09000 CLINIC	0	0	0. 00000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	(C	0. 00000	0 0. 000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(C	0. 00000	0 0. 000000		92.00
200.00 Total (lines 50-199)	0	7, 074, 806			285, 070	200. 00

Health Financial Systems	HARRIS CO PSYCHI	ATRIC CENTER		In Lie	eu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provi der	CCN: 454076	Peri od:	Worksheet D
THROUGH COSTS				From 09/01/2014	
				To 08/31/2015	Date/Time Prepared: 1/28/2016 11:28 am
		Ti tl	e XVIII	Hospi tal	PPS
Cost Center Description	I npati ent	Outpati ent	Outpati ent		
	Program	Program	Program		
	Pass-Through	Charges	Pass-Throug	h	
	Costs (col. 8		Costs (col.	9	
	x col. 10)		x col. 12)		
	11.00	12.00	13.00		
ANCI LLARY SERVI CE COST CENTERS	1 1		1		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	54.00
54. 01 05401 ANCI LLARY SERVI CES	0	0		0	54.01
56. 00 05600 RADI OI SOTOPE	0	0		0	56.00
57.00 05700 CT SCAN	0	0		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	59.00
60. 00 06000 LABORATORY	0	0		0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	67.00
67. 01 06701 THERAPY SERVICES	0	0		0	67.01
67.02 03320 ELECTROSHOCK THERAPY	0	32, 300)	0	67.02
68.00 06800 SPEECH PATHOLOGY	0	0)	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0	73.00
74.00 07400 RENAL DIALYSIS	0	0)	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0)	0	75.00
76.00 03020 PARTIAL HOSPITALIZATION	0	0		0	76.00
OUTPATIENT SERVICE COST CENTERS	<u>.</u>				
88.00 08800 RURAL HEALTH CLINIC	0	0		0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	89.00
90. 00 09000 CLINIC	0	0		0	90.00
91.00 09100 EMERGENCY	0	0		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	92.00
200.00 Total (lines 50-199)	0	32, 300		0	200.00

Health Financial Systems	HARRIS CO PSYCH	IATRIC CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 454076	Peri od:	Worksheet D	
				From 09/01/2014 To 08/31/2015		nared
				10 00/31/2013	1/28/2016 11:	28 am
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge		Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	0.00	(see inst.)	(see inst.)	F 00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0,000000	0		0 0	0	1 54 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0	-	
54. 01 05401 ANCI LLARY SERVI CES	1. 194461	0		0 0	0	
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	
57.00 05700 CT SCAN	0.000000	0		0 0	0	
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0. 000000	0		0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	
60. 00 06000 LABORATORY	0.000000	0		0 0	0	
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0		0 0	0	
66.00 06600 PHYSI CAL THERAPY	0. 000000	0		0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	
67. 01 06701 THERAPY SERVICES	1. 629153	0		0 0	0	
67.02 03320 ELECTROSHOCK THERAPY	1. 741761	32, 300		0 0	56, 259	
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 668629	0		0 0	0	
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	1 1.00
75.00 07500 ASC (NON-DI STINCT PART)	0. 000000	0		0 0	0	
76.00 03020 PARTI AL HOSPI TALI ZATI ON	0. 000000	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	0.00000		1			
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	
90. 00 09000 CLINIC	0.000000	0		0	0	
91.00 09100 EMERGENCY	0. 000000	0		0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0. 000000			0	0	
200.00 Subtotal (see instructions)		32, 300		0 0	56, 259	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0	l	201.00
Only Charges		22.200		0	E4 050	202.00
202.00 Net Charges (line 200 +/- line 201)	l l	32, 300	1	0 0	56, 259	202.00

Health Financial Systems	HARRIS CO PSYCH	ATRIC CENTER		In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 454076	Period: From 09/01/2014	Worksheet D Part V	
				To 08/31/2015	Date/Time Pr	epared:
		T: +1	e XVIII	Hospi tal	1/28/2016 11 PPS	:28 am
	Cos			HOSPITAI	PP5	
Cost Center Description	Cost	Cost	1			
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)	-			
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01 05401 ANCI LLARY SERVI CES	0	0				54.00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57. 00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C				58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	C				59.00
60. 00 06000 LABORATORY	0	C				60.00
60. 01 06001 BLOOD LABORATORY	0	C				60.01
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	C				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
67. 01 06701 THERAPY SERVICES	0	0				67.01
67. 02 03320 ELECTROSHOCK THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	U				67.02 68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74. 00 07400 RENAL DIALYSIS	0	0				74.00
75.00 07500 ASC (NON-DI STINCT PART)	0	0				75.00
76.00 03020 PARTIAL HOSPITALIZATION	0	C				76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	1			89.00
90. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0	0				92.00
200.00Subtotal (see instructions)201.00Less PBP Clinic Lab. Services-Program	0	0				200. 00 201. 00
Only Charges	0					201.00
202.00 Net Charges (line 200 +/- line 201)	0	C				202.00
	-1	-	1			

MPUTA	TION OF INPATIENT OPERATING COST	Provider CCN: 454076	Period: From 09/01/2014 To 08/31/2015	Worksheet D-1 Date/Time Pre 1/28/2016 11:3	pare
		Title XVIII	Hospi tal	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		81, 655	1 1.
00	Inpatient days (including private room days, excluding swing-be	ed and newborn days)		81, 655	
	Private room days (excluding swing-bed and observation bed days	s). If you have only pr	ivate room days,	0	3
	do not complete this line. Semi-private room days (excluding swing-bed and observation be	d days)		81, 655	4
	Total swing-bed SNF type inpatient days (including private room	m days) through Decembe	r 31 of the cost	0	5
	reporting period Total swing-bed SNF type inpatient days (including private roo	m days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	-		0	
00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private room	davs) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)	5		-	
	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	3, 179	9
	Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instruct				
	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		oom days) arter	0	11
	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	a room dave)	0	13
	after December 31 of the cost reporting period (if calendar year)			0	
	Medically necessary private room days applicable to the Program	m (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15
	SWING BED ADJUSTMENT			0	
. 00	Medicare rate for swing-bed SNF services applicable to service	s through December 31 c	f the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service:	s after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
	reporting period	N N		20 250 224	1 21
	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through Decembe		ing period (line	39, 350, 226 0	
	5 x line 17)			-	
	Swing-bed cost applicable to SNF type services after December : x line 18)	31 of the cost reportin	g period (line 6	0	23
	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
	7 x line 19)	1 .6		0	0
	Swing-bed cost applicable to NF type services after December 3 x line 20)	f of the cost reporting	period (inne 8	0	25
	Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	line 21 minus line 26)		39, 350, 226	27
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		-	0	29
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)		+:>	0.00	
	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin		tions)	0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)	· /		0.00	36
	General inpatient routine service cost net of swing-bed cost an	nd private room cost di	fferential (line	39, 350, 226	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
Į	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				1
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 0 x line)	-		481.91	
	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program			1, 531, 992 0	
	Total Program general inpatient routine service cost (line 39	. ,		1, 531, 992	

WPUT	ATION OF INPATIENT OPERATING COST		Provi	der	CCN: 454076	Period: From 09/01/2014 To 08/31/2015	Worksheet D-1 Date/Time Pre	
						10 06/31/2015	1/28/2016 11:	
				Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total I npati ent	Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00		3.00	4.00	5.00	-
00	NURSERY (title V & XIX only)							42
	Intensive Care Type Inpatient Hospital Units							
00	INTENSIVE CARE UNIT	0		0	0.0	0 00	C	
00 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT							44
	SURGICAL INTENSIVE CARE UNIT							40
	OTHER SPECIAL CARE (SPECIFY)							47
	Cost Center Description		•					
							1.00	
00	Program inpatient ancillary service cost (Wks				20)		289,066	
00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instru	CLIO	115)		1, 821, 058	3 49
00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D. sur	n of Parts I and	10, 109	50
	111)							
00	Pass through costs applicable to Program inpa	atient ancillar	ry services	(fr	om Wkst. D, s	sum of Parts II	1, 273	3 51
00	and IV)	50 and E^{1}					11 202	2 52
00 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud		lated non	-phv	sician anesti	netist, and	11, 382 1, 809, 676	
	medical education costs (line 49 minus line !			עייק			.,	
	TARGET AMOUNT AND LIMIT COMPUTATION							
	Program di scharges						C	
00	Target amount per discharge						0.00	
00 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and ta	arget amoun	+ (1	ing 56 minus	line 53)		
00	Bonus payment (see instructions)	ing cost and ta	arget allouri	t (i	The 50 million	TTHE 55)		
00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 199	6, u	pdated and co	ompounded by the	0.00	
	market basket	0.1	0					
00	Lesser of lines 53/54 or 55 from prior year of						0.00	
00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than						C) 61
	amount (line 56), otherwise enter zero (see i		.s (Triles 5	4 🔨		the target		
00	Relief payment (see instructions)	,					C	62
00	Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)				C	63
	PROGRAM INPATIENT ROUTINE SWING BED COST							
00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 or	τne	cost reporti	ng period (See	C	64
00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of t	he c	ost reportino	period (See	C	65
	instructions)(title XVIII only)							
00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus li	ne 6	5)(title XVII	l only). For	C	66
00	CAH (see instructions)	a aaata thraugh	December	21 0	f the east m	nonting noniod	C	
00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December	31 0	r the cost re	eporting period	Ľ	67
00	Title V or XIX swing-bed NF inpatient routine	e costs after D	December 31	of	the cost repo	orting period	C	68
	(line 13 x line 20)					-		
00	Total title V or XIX swing-bed NF inpatient		•		,		C) 69
00	PART III - SKILLED NURSING FACILITY, OTHER NU							70
00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co					,		71
00	Program routine service cost (line 9 x line				,			72
00	Medically necessary private room cost applica				ne 35)			73
00	Total Program general inpatient routine servi	•						74
00	Capital-related cost allocated to inpatient	routine service	e costs (fr	om W	orksheet B, A	art II, column		75
00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)						76
00	Program capital -related costs (line 9 x line							77
00	Inpatient routine service cost (line 74 minus	· · · ·						78
00	Aggregate charges to beneficiaries for excess	• •						79
00	Total Program routine service costs for compa		cost limita	tion	(line 78 mir	nus line 79)		80
00 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li		L)					81
00	Reasonable inpatient routine service cost (· .					83
00	Program inpatient ancillary services (see ins		,					84
00	Utilization review - physician compensation		ons)					85
00	Total Program inpatient operating costs (sum		nrough 85)					86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST						
00		\						
00 00	Total observation bed days (see instructions, Adjusted general inpatient routine cost per o		line 2)				0. 00	

Health Financial Systems	HARRIS CO PSYCH	II ATRI C CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 09/01/2014	Worksheet D-1	
				To 08/31/2015		pared: 28 am
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	259, 940	39, 350, 226	0. 00660	6 0	0	90.00
91.00 Nursing School cost	0	39, 350, 226	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	39, 350, 226	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	39, 350, 226	0.00000	0 0	0	93.00

			To 08/31/2015	Date/Time Prep 1/28/2016 11:2	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	-
	I NPATI ENT DAYS			01 (55	1
	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b	0		81, 655 81, 655	
	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		81, 655	4
00	Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	0	
00	reporting period Total swing-bed SNF type inpatient days (including private roo	m days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	5			
00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Drearon (eveluding	, swing bod and	1, 473	9
00	newborn days)		swillg-bed and	1,475	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		a room day(c)	0	12
. 00	through December 31 of the cost reporting period	Confy (frictuaring privat	e room days)	0	'2
	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13
	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)		-	0	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20
	Total general inpatient routine service cost (see instructions			39, 350, 226	
. 00	Swing-bed cost applicable to SNF type services through Decembe 5×10^{-10}	er 31 of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
	7 x line 19)				
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	or the cost reporting	perioa (line 8	0	25
	Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	<u>Tine 21 minus Tine 26)</u>		39, 350, 226	27
. 00	General inpatient routine service charges (excluding swing-bed	l and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0. 00 0. 00	
	Average per diem private room cost differential (line 34 x lin			0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	inu private room cost di	TTERENTIAL (LINE	39, 350, 226	37
+	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			481.91	38
	Adjusted general inpatient routine service cost per diem (see	I INSTELICITI ONST			
. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	-		709, 853	

WPUT	ATION OF INPATIENT OPERATING COST		Provid	er CCN: 454076	Period: From 09/01/2014 To 08/31/2015		
						1/28/2016 11:	
	Cost Center Description	Total Inpatient Cost	Total	Title XIX Average Pe aysDiem (col. 1 col. 2)		Cost Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
00	NURSERY (title V & XIX only)					L	42
00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0 0	00 0	0	0 43
00	CORONARY CARE UNIT	0		0.	00 0	Ĭ	44
00	BURN INTENSIVE CARE UNIT						45
00	SURGICAL INTENSIVE CARE UNIT						46
00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1 00	-
00	Program inpatient ancillary service cost (Wks	st D-3 col 3	Line 200)			<u> </u>	3 48
00	Total Program inpatient costs (sum of lines 4			tions)		858, 791	
	PASS THROUGH COST ADJUSTMENTS	······································					
00	Pass through costs applicable to Program inpa	atient routine	services (f	rom Wkst. D, su	m of Parts I and	0	50
00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services	(TROM WKST. D,	sum of Parts II	C	51
00	Total Program excludable cost (sum of lines 5	50 and 51)				l c	52
00	Total Program inpatient operating cost exclud		elated, non-	physi ci an anest	hetist, and		
	medical education costs (line 49 minus line 5	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION						
00 00	Program discharges Target amount per discharge					0. 00	
00	Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operati	ng cost and ta	irget amount	(line 56 minus	iline 53)		
00	Bonus payment (see instructions)	5	9	、		C	
00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996	, updated and c	compounded by the	0.00) 59
~~	market basket					0.00	
00 00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines					0.00	
00	which operating costs (line 53) are less than					Ĭ	
	amount (line 56), otherwise enter zero (see i				5		
	Relief payment (see instructions)					C	
. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			0) 63
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of	the cost report	ing period (See	C	64
. 00	instructions) (title XVIII only)	thi ough beec			ing period (see	Ŭ	
00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of th	e cost reportin	ng period (See	0	65 0
	instructions)(title XVIII only)					_	
00	Total Medicare swing-bed SNF inpatient routir	ne costs (line	64 plus lin	e 65)(title XVI	ll only). For	0	66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	December 3	1 of the cost r	eporting period	0	67
. 00	(line 12 x line 19)		becchiber o		opor tring porrod	Ŭ	
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31	of the cost rep	orting period	C) 68
	(line 13 x line 20)					_	
00	Total title V or XIX swing-bed NF inpatient r			,		C) 69
00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili				')	[70
00	Adjusted general inpatient routine service co				1	1	71
00	Program routine service cost (line 9 x line 7					l	72
00	Medically necessary private room cost applica					1	73
00	Total Program general inpatient routine servi	•		,	Devet 11	1	74
00	Capital-related cost allocated to inpatient r 26, line 45)	outine service	e costs (fro	m worкsneet B,	Part II, column	1	75
00	Per diem capital-related costs (line 75 ÷ lir	ne 2)				1	76
00	Program capital -related costs (line 9 x line					l	77
	Inpatient routine service cost (line 74 minus					1	78
00	Aggregate charges to beneficiaries for excess	• •					79
00	Total Program routine service costs for compa		ost limitat	ion (line 78 mi	nus line 79)	ł	80
00 00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li)			1	81
00	Reasonable inpatient routine service cost (s		· .			1	83
00	Program inpatient ancillary services (see ins		- /			l	84
00	Utilization review - physician compensation (ons)			l	85
00	Total Program inpatient operating costs (sum		rough 85)			L	86
00	THAT IN COMPLETENE OF ODCEDVATION DED DACC	THROUGH COST					
	PART IV - COMPUTATION OF OBSERVATION BED PASS						7 0-
00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per c)	line 2)			0. 00	

Health Financial Systems	HARRIS CO PSYCH	II ATRI C CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 09/01/2014 To 08/31/2015	Date/Time Pre 1/28/2016 11:	pared: 28 am
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	259, 940	39, 350, 226	0. 00660	6 0	0	90.00
91.00 Nursing School cost	0	39, 350, 226	0.00000	0 0	0	91.00
92.00 Allied health cost	0	39, 350, 226	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	39, 350, 226	0.00000	0 0	0	93.00

	ncial Systems ANCILLARY SERVICE COST APPORTIONMENT	ARRIS CO PSYCHIATRIC CENTER	CCN: 454076	Po	ri od:	u of Form CMS- Worksheet D-3	
INFALLENT A	ANGILLARI SERVICE CUSI APPORTIUNMENT	FIOVIDEI	CCN. 404070		om 09/01/2014	workSheet D-3	•
				То		Date/Time Pre	
						1/28/2016 11:	28 am
		liti	e XVIII	<u> </u>	Hospi tal	PPS	
	Cost Center Description		Ratio of Co		Inpatient Program	Inpatient	
			To Charges	>		Program Costs (col. 1 x col.	
					charges	2)	
			1.00		2.00	3.00	<u> </u>
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
	0 ADULTS & PEDI ATRI CS				2, 543, 262		30. 0
31.00 0310	O INTENSIVE CARE UNIT				0		31.0
	LLARY SERVICE COST CENTERS						
	0 RADI OLOGY-DI AGNOSTI C		0.0000		0	0	
	1 ANCI LLARY SERVI CES		1. 1944		26, 415	31, 552	
	0 RADI 0I SOTOPE		0.0000		0	0	
	O CT SCAN		0.0000		0	0	
	O MAGNETIC RESONANCE I MAGING (MRI)		0.0000		0	0	
	O CARDI AC CATHETERI ZATI ON		0.0000		0	0	
	0 LABORATORY 1 BLOOD LABORATORY		0.0000		0	0	00.0
	ORESPIRATORY THERAPY		0.0000		0	0	
	0 PHYSI CAL THERAPY		0.0000		0	0	1
	0 OCCUPATI ONAL THERAPY		0.0000		0	0	
	1 THERAPY SERVICES		1. 629		82, 348	134, 157	
	O ELECTROSHOCK THERAPY		1. 7412		5, 100	8, 883	
	O SPEECH PATHOLOGY		0.0000		0	0	
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000	000	0	0	71.0
72.00 0720	OIMPL. DEV. CHARGED TO PATIENTS		0.0000	000	0	0	72.0
	O DRUGS CHARGED TO PATIENTS		0.6686	529	171, 207	114, 474	73.0
	0 RENAL DIALYSIS		0.0000		0	0	
	O ASC (NON-DISTINCT PART)		0.0000		0	0	1 / 0/ 0
	O PARTIAL HOSPITALIZATION		0.0000	000	0	0	76.0
	ATIENT SERVICE COST CENTERS						
	O RURAL HEALTH CLINIC		0.0000			0	
	0 FEDERALLY QUALIFIED HEALTH CENTER 0 CLINIC		0.0000			0	
	O EMERGENCY		0.0000		0	0	
	O OBSERVATION BEDS (NON-DISTINCT PART)		0.0000		0	0	
200.00	Total (sum of lines 50-94 and 96-98)		0.0000	.00	285, 070	289, 066	
200.00	Less PBP Clinic Laboratory Services-Pro	gram only charges (line 61)			203, 070	207,000	200.0
202.00	Net Charges (line 200 minus line 201)	gram only charges (rille 01)		1	0		201.0

	2	ARRIS CO PSYCHIATRIC CENTER	CON 454074		eu of Form CMS-	
INPAILENI A	ANCILLARY SERVICE COST APPORTIONMENT	Provider	CCN: 454076	Period: From 09/01/2014	Worksheet D-3	3
				To 08/31/2019	5 Date/Time Pre	
					1/28/2016 11:	28 am
		Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program Charges	Program Costs (col. 1 x col.	
				charges	2)	
			1.00	2.00	3.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS					
	0 ADULTS & PEDIATRICS			1, 176, 15	D	30. 00
31.00 0310	O INTENSIVE CARE UNIT			(o	31.00
	LLARY SERVICE COST CENTERS		-		-	
	0 RADI OLOGY-DI AGNOSTI C		0.0000		0 0	
	1 ANCI LLARY SERVI CES		1. 1944			
	0 RADI 0I SOTOPE		0.0000		0 0	
	O CT SCAN		0.0000		0 0	
	O MAGNETIC RESONANCE I MAGING (MRI)		0.0000		0 0	
	O CARDI AC CATHETERI ZATI ON		0.0000			
	0 LABORATORY 1 BLOOD LABORATORY		0.0000			00.0
	O RESPIRATORY THERAPY		0.0000			
	O PHYSI CAL THERAPY		0.0000			
	0 OCCUPATIONAL THERAPY		0.0000			
	1 THERAPY SERVICES		1. 6291			
	O ELECTROSHOCK THERAPY		1.7417		0 0	
68.00 0680	O SPEECH PATHOLOGY		0.0000	00	o o	68.00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000	00	o o	71.00
	OIMPL. DEV. CHARGED TO PATIENTS		0.0000		0 0	
	O DRUGS CHARGED TO PATIENTS		0. 6686		8 42, 256	73.00
	0 RENAL DIALYSIS		0.0000		0 0	
	O ASC (NON-DISTINCT PART)		0.0000		0 0	1 / 0 / 0
	O PARTI AL HOSPI TALI ZATI ON		0.0000	00	0 0	76.00
	ATLENT SERVICE COST CENTERS		0.000			
	O RURAL HEALTH CLINIC		0.0000			
	O FEDERALLY QUALIFIED HEALTH CENTER O CLINIC		0.0000			
	0 EMERGENCY		0.0000			
	O OBSERVATION BEDS (NON-DISTINCT PART)		0.0000			
200.00	Total (sum of lines 50-94 and 96-98)		0.0000	133, 77	-	
201.00	Less PBP Clinic Laboratory Services-Prod	gram only charges (line 61)		155,77	0	201.00
202.00	Net Charges (line 200 minus line 201)			133, 77		202.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 454076	Period: From 09/01/2014 To 08/31/2015	Worksheet E Part B Date/Time Prep 1/28/2016 11:2	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
00	Medical and other services (see instructions)	-)		0	1.0
00 00	Medical and other services reimbursed under OPPS (see instruction PPS payments	S)		56, 259 16, 632	2.0 3.0
00	Outlier payment (see instructions)			0,032	4.0
00	Enter the hospital specific payment to cost ratio (see instructio	ns)		0.000	5. C
00	Line 2 times line 5			0	6.0
00 00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0.00 0	
00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13. line 200		0	9.0
. 00	Organ acqui si ti ons			0	10.0
. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.0
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
. 00	Ancillary service charges			0	12.0
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		0	
. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. (
. 00	Customary charges Aggregate amount actually collected from patients liable for paym	ont for convious on	a charga baci c	0	15. (
	Amounts that would have been realized from patients liable for pa		0	0	16.0
	had such payment been made in accordance with 42 CFR §413.13(e)		r a onar gobaor o	5	
. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.00000	
	Total customary charges (see instructions)	fling 10 gyogoda li	a 11) (aaa	0	
. 00	Excess of customary charges over reasonable cost (complete only i instructions)	I TIME 18 exceeds III	le II) (see	0	19. (
. 00	Excess of reasonable cost over customary charges (complete only i	fline 11 exceeds li	ne 18) (see	0	20.
	instructions)			_	
	Lesser of cost or charges (line 11 minus line 20) (for CAH see in Interns and residents (see instructions)	structions)		0	
	Cost of physicians' services in a teaching hospital (see instruct	ions)		0	22.0
	Total prospective payment (sum of lines 3, 4, 8 and 9)			16, 632	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for CA	H soo instructions)		3, 326 0	25. 26.
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus		and 231 (see	13, 306	
	instructions)				
	Direct graduate medical education payments (from Wkst. E-4, line	50)		1, 289	
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 14, 595	
	Primary payer payments			14, 393	31.
	Subtotal (line 30 minus line 31)			14, 595	32.
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see instruct	ions)		0	36.
	Subtotal (see instructions)			14, 595	
	MSP-LCC reconciliation amount from PS&R			0	38.
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	
. 98		devices (see instruc	tions)	0	39.
. 99	RECOVERY OF ACCELERATED DEPRECIATION	,		0	
	Subtotal (see instructions)			14, 595	
	Sequestration adjustment (see instructions)			292	
	Interim payments Tentative settlement (for contractors use only)			13, 040 0	41. 42.
. 00	Balance due provider/program (see instructions)			1, 263	
	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	chapter 1,	0	
	\$115.2				
00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
				0	93.

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 454076	Period: From 09/01/2014 To 08/31/2015		pared
		Title	e XVIII	Hospi tal	PPS	
		I npati en	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		2, 305, 8	66 0	13, 040 0	1. 2. 3.
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	ADJUSTMENTS TO PROVIDER	03/05/2015	24, 9		0	3.
02 03				0	0	3.
)3)4				0	0	
)4)5				0	0	
	Provider to Program			<u> </u>		
50	ADJUSTMENTS TO PROGRAM			0	0	3 3
1				0	0	
52				0	0	3
53				0	0	
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		24, 9	0	0	3
7	3. 50-3. 98)		24, 7	57	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 330, 8	25	13, 040	4
	TO BE COMPLETED BY CONTRACTOR			1		
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5
)1	TENTATI VE TO PROVI DER			0	0	15
)2				0	0	5
3				0	0	5
~	Provider to Program	1				_
50 51	TENTATI VE TO PROGRAM			0	0	5
52				0	0	5
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
0	5.50-5.98)					,
00	Determined net settlement amount (balance due) based on the cost report. (1)				1 0/0	6
)1)2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		34, 0	0	1, 263	6
)2)0	Total Medicare program liability (see instructions)		34, 0 2, 296, 7		14, 303	
.0			2,270,7	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		0		1.00	2.00	

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 454076	Period: From 09/01/2014	Worksheet E-3 Part II	
			To 08/31/2015	Date/Time Pre 1/28/2016 11:	
		Title XVIII	Hospi tal	PPS	20 011
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and med	lical education payments)		2, 430, 643	1.0
2.00	Net IPF PPS Outlier Payments			0	2.0
8.00	Net IPF PPS ECT Payments			0	3.0
. 00	Unweighted intern and resident FTE count in the most recent c	cost report filed on or b	efore November	12.89	4.0
l. 01	15, 2004. (see instructions) Cap increases for the unweighted intern and resident FTE coun	t for residents that wer	o displaced by	0.00	4.0
F. UT	program or hospital closure, that would not be counted without			0.00	4.0
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)				
5.00	New Teaching program adjustment. (see instructions)			0.00	5.0
o. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	period of a "new	16.60	6.0
	teaching program" (see instuctions)				
. 00	Current year's unweighted I&R FTE count for residents within	the new program growth p	period of a "new	0.00	7.0
	teaching program" (see instuctions)			10.00	
3.00 9.00	Intern and resident count for IPF PPS medical education adjus Average Daily Census (see instructions)	stment (see instructions)		12. 89 223. 712329	8. C 9. C
0.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	the nower of $5150 - 1$		0. 029271	
1.00	Teaching Adjustment (line 1 multiplied by line 10).	the power of . 5150 -13.		71, 147	
2.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2, 501, 790	
3.00	Nursing and Allied Health Managed Care payment (see instructi	on)		0	13.
4.00	Organ acquisition (DO NOT USE THIS LINE)				14. (
5.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	15. (
6.00	Subtotal (see instructions)			2, 501, 790	16. (
7.00	Primary payer payments			2, 281	
8.00	Subtotal (line 16 less line 17).			2, 499, 509	
9.00	Deducti bl es			262, 341	
20.00	Subtotal (line 18 minus line 19) Coinsurance			2, 237, 168	
21.00	Subtotal (line 20 minus line 21)			61, 035 2, 176, 133	
23.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		193, 519	
24.00	Adjusted reimbursable bad debts (see instructions)			125, 787	
25.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	25.0
6.00	Subtotal (sum of lines 22 and 24)			2, 301, 920	26. (
7.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		41, 685	27.(
8.00	Other pass through costs (see instructions)			0	
9.00	Outlier payments reconciliation			0	
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	- >		0	
30.50 30.99	Pioneer ACO demonstration payment adjustment (see instruction Recovery of Accelerated Depreciation	IS)		0	
1.00	Total amount payable to the provider (see instructions)			2, 343, 605	
1.01	Sequestration adjustment (see instructions)			46, 872	
2.00	Interim payments			2, 330, 825	
3.00	Tentative settlement (for contractor use only)			0007,020	
84.00	Balance due provider/program (line 31 minus lines 31.01, 32 a	ind 33)		-34, 092	
35.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	35. C
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				_
0.00	Original outlier amount from Worksheet E-3, Part II, line 2			0	
51.00 52.00	Outlier reconciliation adjustment amount (see instructions)			-	51.0
	The rate used to calculate the Time Value of Money			0.00	1 52.(

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	rovider CCN: 454076	Period: From 09/01/2014 To 08/31/2015	Worksheet E-3 Part VII Date/Time Pre	pared:
		Title XIX	Hospi tal	1/28/2016 11: Cost	28 am
		II LIE XIX	Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	ES FOR TITLES V OR X	I X SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		858, 791		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	0	3.00
4.00 5.00	Subtotal (sum of lines 1, 2 and 3)		858, 791	0	4.00
6.00	Inpatient primary payer payments Outpatient primary payer payments		0	0	•
7.00	Subtotal (line 4 less sum of lines 5 and 6)		858, 791	0	
	COMPUTATION OF LESSER OF COST OR CHARGES		000,771		
	Reasonabl e Charges				1
8.00	Routi ne servi ce charges		1, 176, 150		8.00
9.00	Ancillary service charges		133, 777	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1, 309, 927	0	12.00
13.00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for ser	avisos on a charge	0	0	13.00
13.00	basis	vices on a charge	0	0	13.00
14.00	Amounts that would have been realized from patients liable for pay	vment for services o	n 0	0	14.00
	a charge basis had such payment been made in accordance with 42 CF			Ũ	
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	- ()	0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1, 309, 927	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if	Fline 16 exceeds	451, 136	0	17.00
10.00	line 4) (see instructions)			0	10.00
18.00	Excess of reasonable cost over customary charges (complete only if	Fline 4 exceeds lin	e O	0	18.00
19.00	16) (see instructions) Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructi	ons)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		858, 791	0	•
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	oleted for PPS provi			
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	•
27.00	Subtotal (sum of lines 22 through 26)		0	0	
28.00 29.00	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)		858, 791	0	28.00
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		030, 771	0	29.00
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)		858, 791	0	•
32.00	Deducti bl es		0	0	•
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	•
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33))	858, 791	0	•
37.00	ADJUSTMENT TO REMOVE SETTLEMENT		-103, 139	0	37.00
38.00 39.00	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)		755, 652	0	38.00 39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		755, 652	0	•
40.00	Interim payments		755, 652	0	
42.00	Balance due provider/program (line 40 minus line 41)		, 55, 652	0	1
43.00	Protested amounts (nonallowable cost report items) in accordance v	with CMS Pub 15-2.	0	0	
	chapter 1, §115.2			-	

	Financial Systems HARRIS CO PSYCHIATI GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT		CCN: 454076	Peri od:	u of Form CMS-2 Worksheet E-4	
	_ EDUCATION COSTS	FIOVIDEI	CCN. 454070	From 09/01/2014 To 08/31/2015	Date/Time Pre	
					1/28/2016 11:	28 an
		liti	e XVIII	Hospi tal	PPS	
					1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
	Unweighted resident FTE count for allopathic and osteopathic p ending on or before December 31, 1996.	0		0.1	41.74	1.0
	Unweighted FTE resident cap add-on for new programs per 42 CFR		1) (see instr	ructions)	0.00	2.
	Amount of reduction to Direct GME cap under section 422 of MMA		6412 70 (m)	(222	21.89	3. 3.
	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)	WI LII 42 CFR	9413.79 (11).	(566	4. 10	3.
00	Adjustment (plus or minus) to the FTE cap for allopathic and or GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	steopathi c	programs due	to a Medicare	0.00	4.
01	ACA Section 5503 increase to the Direct GME FTE Cap (see instru	uctions for	cost reporti	ng periods	0.00	4.
02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slots	(see inst	ructions for	cost reporting	0.00	4.
. 00	periods straddling 7/1/2011) FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plu:	s or minus	line 4 plus l	ines 4.01 and	15.75	5.
. 00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic p	rograms for	the current	year from your	16.60	6.
1	records (see instructions) Enter the lesser of line 5 or line 6				15. 75	7.
			Primary Care		Total	
00	Weighted FTF count for above since in an ellemethic and establish	+ - -	1.00	2.00	3.00	
	Weighted FTE count for physicians in an allopathic and osteopa program for the current year.		0.0		15.03	8.
	If line 6 is less than 5 enter the amount from line 8, otherwis multiply line 8 times the result of line 5 divided by the amoun 6.		0.0	00 14.26	14.26	9.
1	Weighted dental and podiatric resident FTE count for the curre	nt year		0.00		10.
1	Total weighted FTE count	5	0.0	14.26		11.
	Total weighted resident FTE count for the prior cost reporting	year (see	0.0	00 11.25		12.
3. 00	instructions) Total weighted resident FTE count for the penultimate cost rep	orting	0.0	00 11.25		13.
	year (see instructions)	2)		10.05		1.
	Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	oy 3).	0. (0. (14. 15.
	Adjustment for residents firminal years of new programs Adjustment for residents displaced by program or hospital clos	ure	0.0			16.
	Adjusted rolling average FTE count	ure	0.0			17.
	Per resident amount		90, 107. 8			18.
	Approved amount for resident costs			0 1, 103, 821	1, 103, 821	
	Additional sumministed allowsthing and astronathing dispect CNE ET			alizzadi unadaria 40	1.00	20
	Additional unweighted allopathic and osteopathic direct GME FT Sec. 413.79(c)(4)	E resident	cap slots rec	erved under 42	0.00	20.
1	Direct GME FTE unweighted resident count over cap (see instruc	tions)			0.85	21.
	Allowable additional direct GME FTE Resident Count (see instru				0.00	
3.00	Enter the locally adjustment national average per resident among	unt (sée in	structions)		0.00	23.
	Multiply line 22 time line 23				0	24.
5.00	Total direct GME amount (sum of lines 19 and 24)				1, 103, 821	25.
			Inpatient Par A	t Managed care		
			1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
	Inpatient Days (see instructions)		3, 17			26.
	Total Inpatient Days (see instructions)		81, 65			27.
	Ratio of inpatient days to total inpatient days		0. 03893			28.
	Program direct GME amount		42, 97			29.
30.00	Reduction for direct GME payments for Medicare Advantage			0		30.
	Net Program direct GME amount			1	42, 974	1 21

and 94)33.00Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)034.00Ratio of direct medical education costs to total charges (line 32 + line 33)0036.00Medicare outpatient ESRD charges (see instructions)0036.00Medicare outpatient ESRD on MEDICARE REASONABLE COST - TITLE XVIII ONLYPart A Reasonable Cost7.00Reasonable cost (see instructions)000000010010110111 <tr< th=""><th>Heal th</th><th>Financial Systems</th><th>HARRIS CO PSYCHIATR</th><th>I C CENTER</th><th>In Lie</th><th>u of Form CMS-2</th><th>2552-10</th></tr<>	Heal th	Financial Systems	HARRIS CO PSYCHIATR	I C CENTER	In Lie	u of Form CMS-2	2552-10
To 08/31/2015 Date/Time Prepared: 1/28/2016 11:28 am DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS) 1.00 32.00 Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) 0 32.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) 0 33.00 Renal dialysis chare cutpatient ESRD composition costs to total charges (line 32 + line 33) 0.0000000 34.00 Ratio of direct medical education costs (line 34 x line 35) 0 35.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) 0 36.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) 0 36.00 Reasonable cost 1, 821, 058 37.00 37.00 Reasonable cost (see instructions) 0 38.00 38.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) 0 38.00 30.00 Reasonable cost (see instructions) 0 38.00 30.00 Total Part A reasonable cost 56.259 42.00 42.00 Reasonable cost (sum of lines 37 through 39 minus line 40) 1, 818, 777	DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OU	JTPATIENT DIRECT	Provider CCN: 454076		Worksheet E-4	
Image: construction const services in a teaching hospital (see instructions) 1/28/2016 11:28 am Image: construction const services in a teaching hospital (see instructions) 0 Image: construction const services in a teaching hospital (see instructions) 0 Image: construction const services in a teaching hospital (see instructions) 0 Image: construction const services in a teaching hospital (see instructions) 0 Image: construction const services in a teaching hospital (see instructions) 0 Image: construction const services in a teaching hospital (see instructions) 0 Image: construction const services in a teaching hospital (see instructions) 0 Image: construction const services in a teaching hospital (see instructions) 0 Image: construction const services in a teaching hospital (see instructions) 0 Image: const services in a teaching hospital (see instructions) 0 Image: const services in a teaching hospital (see instructions) 0 Image: const services in a teaching hospital (see instructions) 0 Image: const services in a teaching hospital (see instructions) 0 Image: const services in a teaching hospital (see instructions) 0 Image: const services in a teaching hospital (see instructions) 0 Image: const services in a t	MEDI CA	L EDUCATION COSTS				Data/Tima Dray	narod
Title XVIII Hospital PPS DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS) 1.00 32.00 Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) 0 32.00 33.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) 0 33.00 34.00 Renal dialysis and home dialysis total charges (line 32 + line 33) 0.000000 34.00 35.00 Medicare outpatient ESRD charges (see instructions) 0 35.00 36.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) 0 0 36.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) 0 36.00 37.00 Reasonable cost (see instructions) 1,821,058 37.00 37.00 Reasonable cost (see instructions) 0 39.00 38.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) 0 38.00 39.00 Cost of physicians' services in a teaching hospital (see instructions) 0 39.00 41.00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) 1,818,777 <					10 06/31/2013		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS) 1.00 32.00 Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) 0 32.00 33.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) 0 33.00 34.00 Retai of direct medical education costs to total charges (line 32 + line 33) 0.000000 34.00 35.00 Medicare outpatient ESRD charges (see instructions) 0 0 35.00 36.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) 0 0 36.00 APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY Part A Reasonable Cost 0 38.00 37.00 Reasonable cost (see instructions) 0 0 38.00 38.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) 0 38.00 0 39.00 Cost of physicians' services in a teaching hospital (see instructions) 0 39.00 0 39.00 30.00 Primary payer payments (see instructions) 0 1.818,777 0 34.00 31.00 Primary payer payments (see i				Title XVIII	Hospi tal		
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	48.00	Total program GME payment (line 31)				42, 974	48.00
47. UU Part A Medicale GME payment (The 40 x 40) (Little AVIII ONLY) (See Instructions) $41,000$ [41,000] 49. UU	49.00		(title XVIII only) (see instructions)		41, 685	49.00
50.00 Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions) 1,289 50.00	50.00	Part B Medicare GME payment (line 47 x 48)	(title XVIII only) (see instructions)		1, 289	50.00

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column onl		1	Period: From 09/01/2014	Worksheet G	
				Го 08/31/2015	Date/Time Pre 1/28/2016 11:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	0		0 0	0	1.
00	Temporary investments	0			0	
00	Notes receivable	0		0 0	0	
00	Accounts receivable	10, 652, 070		0 0	0	4.
00	Other receivable	872, 902		0 0	0	
00	Allowances for uncollectible notes and accounts receivable	-9, 404, 088		0 0	0	
00 00	Inventory Prepaid expenses	157, 573 17, 802			0	
00	Other current assets	17, 802			0	
00	Due from other funds	8, 970, 603		0	0	
. 00	Total current assets (sum of lines 1-10)	11, 266, 862		0 0	0	
	FI XED ASSETS					
. 00	Land	0		0 0	0	
. 00	Land improvements	0		0 0	0	
. 00	Accumulated depreciation	0		0	0	
. 00 . 00	Buildings Accumulated depreciation				0	
. 00	Leasehold improvements				0	
. 00	Accumulated depreciation	0		0	0	
. 00	Fixed equipment	0	(o o	0	19
. 00	Accumulated depreciation	0	(0 0	0	20
. 00	Automobiles and trucks	0		0 0	0	
. 00	Accumulated depreciation	0		0 0	0	
. 00	Major movable equipment	0		0 0	0	
. 00 . 00	Accumulated depreciation Minor equipment depreciable				0	
. 00	Accumulated depreciation				0	
. 00	HIT designated Assets	0			0	
. 00	Accumulated depreciation	0		0 0	0	
. 00	Mi nor equi pment-nondepreci abl e	0		0 0	0	29
. 00	Total fixed assets (sum of lines 12-29)	0	(0 0	0	30
00	OTHER ASSETS					
. 00 . 00	Investments Deposits on Leases	0			0	
. 00	Due from owners/officers				0	
. 00	Other assets	0		0	0	
. 00	Total other assets (sum of lines 31-34)	0		0 0	0	
. 00	Total assets (sum of lines 11, 30, and 35)	11, 266, 862	(o o	0	36
	CURRENT LI ABI LI TI ES					
. 00	Accounts payable	2, 532, 146		0 0	0	
. 00	Salaries, wages, and fees payable	0		0 0	0	
. 00	Payroll taxes payable	0		0	0	
. 00 . 00	Notes and loans payable (short term) Deferred income				0	
. 00	Accel erated payments	0	,		0	42
. 00	Due to other funds	0	(o o	0	
. 00	Other current liabilities	0	(0 0	0	44
. 00	Total current liabilities (sum of lines 37 thru 44)	2, 532, 146	(0 0	0	45
00	LONG TERM LIABILITIES					
. 00 . 00	Mortgage payable Notes payable				0	
. 00	Unsecured Loans				0	
. 00	Other long term liabilities	1 0			0	
. 00	Total long term liabilities (sum of lines 46 thru 49	0		0 0	0	
. 00	Total liabilites (sum of lines 45 and 50)	2, 532, 146	(0 0	0	51
	CAPI TAL ACCOUNTS			1		
. 00	General fund balance	8, 734, 716				52
. 00	Specific purpose fund					53
. 00 . 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54
. 00	Governing body created - endowment fund balance - unrestricted					56
. 00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				c c	-
. 00	Total fund balances (sum of lines 52 thru 58)	8, 734, 716		0 0	0	
. 00	Total liabilities and fund balances (sum of lines 51 and	11, 266, 862	1 (n ol	0	60

		CCN: 454076		1/28/2016 11:	pared: 28 am
General	Fund	Speci al	Purpose Fund	Endowment Fund	
1.00		3.00		5.00	1 00
0 0 0 0 0 0 1, 374, 755 0 0 0 0 0 0	10, 532, 334 -422, 863 10, 109, 471 0, 109, 471 10, 109, 471 1, 374, 755 8, 734, 716			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
Endowment Fund	PI ant	Fund			
(00	7.00	0.00			
	7.00	8.00	0		1.00
0	0 0 0 0 0		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
000	0 0 0 0 0 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
	I.00 1.00 0	10, 532, 334 -422, 863 10, 109, 471 0 1, 374, 755 8, 734, 716 Endowment Fund 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <	Image: constraint of the constrated of the constraint of the constraint of the constraint of the	General Fund Special Purpose Fund 1.00 2.00 3.00 4.00 10,532,334 0 0 0 -422,863 10,109,471 0 0 0 0 0 0 0 0 0 0 0 <td>Iteration To 08/31/2015 Date/Time Pre- 1/28/2016 To Iteration Special Purpose Fund Endowment Fund Iteration 3.00 4.00 5.00 5.00 Iteration -422, 863 0 - 0 0 0 -422, 863 0<!--</td--></td>	Iteration To 08/31/2015 Date/Time Pre- 1/28/2016 To Iteration Special Purpose Fund Endowment Fund Iteration 3.00 4.00 5.00 5.00 Iteration -422, 863 0 - 0 0 0 -422, 863 0 </td

	Financial Systems HARRIS CO PSYCHIATR		00N 45 407 (u of Form CMS-2	
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 454076	Period: From 09/01/2014 To 08/31/2015		pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
1 00	General Inpatient Routine Services		(5 222 7	00	(F 222 700	1 1 00
1.00 2.00	Hospi tal SUBPROVI DER – I PF		65, 323, 7	90	65, 323, 790	1.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY			0	0	8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		65, 323, 7	90	65, 323, 790	10.00
	Intensive Care Type Inpatient Hospital Services		1			
11.00	INTENSIVE CARE UNIT			0	0	
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of I	nes		0	0	16.00
17.00	11-15) Total inpatient routine care services (sum of lines 10 and 16)		65, 323, 7	90	65, 323, 790	17.00
18.00	Ancillary services		6, 963, 4			
19.00	Outpati ent servi ces		0, 703, 4	0 111, 350		
20.00	RURAL HEALTH CLINIC			0 0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	PHYSI CI AN CHARGES		8, 004, 0		8, 004, 014	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.	80, 291, 2	60 111, 350	80, 402, 610	28.00
	G-3, line 1)					-
20.00	PART II - OPERATING EXPENSES			50, 546, 089		200.00
29.00 30.00	Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY)			50, 546, 089 0		29.00 30.00
31.00	ADD (SPECIFT)			0		30.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		50, 546, 089		43.00
	to Wkst. G-3, line 4)					

llool th	Financial Sustana UADDIC CO DEVCULATI			u of Form CNC (NEE2 10
	Financial Systems HARRIS CO PSYCHIATI			u of Form CMS-2	2552-10
STATEN	ENT OF REVENUES AND EXPENSES	Provider CCN: 454076	Period: From 09/01/2014	Worksheet G-3	
			To 08/31/2015	Date/Time Pre	pared:
				1/28/2016 11:	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		80, 402, 610	1.00
2.00	Less contractual allowances and discounts on patients' account	S		73, 080, 312	2.00
3.00	Net patient revenues (line 1 minus line 2)			7, 322, 298	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 4	3)		50, 546, 089	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-43, 223, 791	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			131, 514	7.00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other th	an patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			6, 479, 589	23.00
24.00	OTHER (SPECIFY)			0	24.00
24.01	JUVENI LE DETENTION			0	24.01
24.02	RESIDENTIAL TREATMENT CENTER			0	24.02
24.03	BUDGETED INCOME REALIZED			0	24.03
24.04	HARRIS COUNTY CONTRACT			10, 554, 813	24.04
24.05	MHMR TRANSFERS			27, 752, 381	24.05
24.06	MCR OTHER			338, 848	24.06
24.07	MISC INCOME UNRES			61, 018	24.07
24.08	BAD DEBT RECOVERIES			13, 472	24.08
24.09	FORENSI C UNI T			0	24.09
24.10	HCPC BTGH & CNTY HOSPITALS			0	24.10
24.11	OTHER INCOME			-2, 530, 707	24.11
25.00	Total other income (sum of lines 6-24)			42, 800, 928	25.00
26.00	Total (line 5 plus line 25)			-422, 863	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			-422, 863	29.00



Investment Trades

Report ID: BSHCPC Report Layout: GLDM_BALSHEET_RV Run: October 14, 2015 at 09:01 PM	-	Current Year Year-to-Date Primary	Prior Year Year-to-Date Primary	Net Change Year-to-Date Primary
ASSETS	Account	University	University	University
Current Assets:	rooount			
Cash & Cash Equivalents	- \$			
Restricted Cash & Cash Equivalents	- *			
Balance in State Appropriations	_			
Funds Held by System Administration - Current	_	<u>_</u>		
Securities Lending Collateral	_	<u>_</u>		
Accounts Receivable, Net:				
Federal Receivables	_			
Other Intergovernmental Rec.	_			
Student Receivables	-			
Patient Receivables	-	527,388.38	571,368.34	(43,979.97)
Interest and Dividends	-	527,500.50	571,500.54	(43,979.97)
Contributions Receivable	-			
	-			
Investment Trades	-	-		(4, 200, 540, 02)
Other Receivables	-	1,549,606.13	2,850,154.95	(1,300,548.82)
Federal Contracts and Grants	-			
Other Contracts and Grants	-	0 4 5 0 7 0 0 4	7 045 540 00	
Due From Other Funds	-	8,152,799.21	7,215,543.63	937,255.58
Due From System Administration	-			
Due From Other Components*	-			
Due From Other Agencies	-			
Inventories	-	157,573.49	128,643.18	28,930.31
Loans and Contracts	-			(1,000,00)
Other Current Assets	-	17,801.64	19,624.84	(1,823.20)
Total Current Assets	\$_	10,405,168.85	10,785,334.95	(380,166.10)
Restricted: Investments Loans, Contracts and Other Funds Held by System Administration	- \$ - -			
Funds Held by System - Permanent Health Fund	-			
Funds Held by Sealy & Smith Foundation	-	-	-	-
Contributions Receivable	-			
Investments	-			
Other Non-Current Assets	-			
Capital Assets	-		1,015,935.02	(1,015,935.02)
Less: Accumulated Depreciation		-	-	-
Total Non-Current Assets	_		1,015,935.02	(1,015,935.02)
TOTAL ASSETS	\$_	10,405,168.85	11,801,269.97	(1,396,101.12)
LIABILITIES				
Current Liabilities:	0.4000	10 000 00	100.000.05	
Vouchers Payable	24000	42,283.63	129,229.85	(86,946.22)
Miscellaneous Accounts Payable	24004	A-- - - -	49,335.42	(49,335.42)
Acct Payable-Received&Accrued	24016	370,155.02	357,280.56	12,874.46
Vouchers Payable-Internal Svcs	24021	(0.00)	(0.00)	
Accrued Liabilities	24300	74,686.67	66,820.24	7,866.43
Accrued Utilities-HCPC	24312	61,647.07	31,016.56	30,630.51
Accounts Payable and Accrued Liabilities	- \$	548,772.39	633,682.63	(84,910.24)
Salaries Payables		92,206.04	88,097.36	4,108.68
Federal Payables	-	-	-	-
Other Intergovernmental Payables	-	-	-	-
Investment Trades	_		_	

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Report ID: BSHCPC Report Layout: GLDM_BALSHEET_RV		Current Year Year-to-Date	Prior Year Year-to-Date	Net Change Year-to-Date
Run: October 14, 2015 at 09:01 PM		Primary University	Primary University	Primary University
Self-Insurance Claims IBNR	-	-	-	-
Securities Lending Obligations	-	-	-	-
Due to Other Funds	-			
Due to System Administration	-			
Due to Other Components*	-			
Due to Other Agencies	-			
Deferred Revenue	-			
Employees' Compensable Leave-Current Portion	-	777,561.61	777,561.61	
Notes, Loans, and Lease Payable				
Revenue Bonds Payable-Current Portion	-	-	-	-
HEAF Bonds Payable-Current Portion	-	-	-	-
Funds Held for Others	-	-	-	-
Other Current Liabilities	-	2,052.11	2,052.11	
Clearing Account	-	317,624.04	142,755.17	174,868.87
Encumbrances	-	1,089,672.73	1,158,260.26	(68,587.53)
Total Current Liabilities	\$	2,827,888.92	2,802,409.14	25,479.78
Non-Current Liabilities:				
Employees' Compensable Leave	-	597,193.72	597,193.72	
Assets Held for Others	-			
Held in Custody for Others	-			
Notes, Loans and Leases Payable	-			
Payable From Restricted Assets	-	-	-	-
Revenue Bonds Payable	-	-	-	-
HEAF Bonds Payable	-	-	-	-
Other Non-Current Liabilities		507 400 70	507 400 70	
Total Non-Current Liabilities TOTAL LIABILITIES	¢	<u>597,193.72</u> 3,425,082.64	<u>597,193.72</u> 3,399,602.86	25,479.78
	Ψ	3,423,002.04	0,0002.00	20,479.70
NET ASSETS				
Invested in Capital Assets, Net of Related Debt	\$			
Restricted for:	Ŧ			
Nonexpendable				
Permanent University Fund Endowment	-	-	-	-
True and Other Endowments, and Annuities	-	-	-	-
True and Other Endowments Held for Components	-	-	-	-
Expendable				
Capital Projects	-	-	-	-
Debt Service	-	-	-	-
Funds Functioning as Endowment - Restricted	-	-	-	-
Funds Funct. as Endow - Restr. Held for Components	-	-	-	-
Other Expendable	-			
Unrestricted				
Fund Balance	-	8,543,992.35	8,880,909.47	(336,917.12)
State Appropriations	40401	6,479,589.49	5,923,138.53	556,450.96
HCPC Contractual Revenue	41011	7,090,036.11	6,533,293.80	556,742.31
Miscellaneous Income-Unres	41025	39,547.26	51,739.45	(12,192.19)
Investment Income	41043	131,514.18	124,953.90	6,560.28
AM Capital Asset Proceeds	41056		(3,514.91) 5 727 051 82	3,514.91
HCPC Medicare Patient Revenue HCPC Medicaid Patient Services	41066	5,358,097.30	5,737,951.82	(379,854.52)
	41067 41068	2,455,535.81	2,945,766.33	(490,230.52) 477 423 81
HCPC Medicaid Mgd Care Pt Svcs HCPC Commercl Patient Services	41068	3,202,308.83 3,878,998.48	2,724,885.02	477,423.81 272,023.49
HCPC Commerci Patient Services HCPC Indigent Care Pat Servs	41069	3,878,998.48 18,697,101.79	3,606,974.99 20,662,523.12	(1,965,421.33)
HCPC Indigent Care Pat Servis HCPC Other Patient Services	41070	12,768,824.59	20,662,523.12 12,139,807.15	(1,965,421.33) 629,017.44
		12,700,024.03	12,100,007.10	023,017.44



Report ID: BSHCPC Report Layout: GLDM_BALSHEET_RV		Current Year Year-to-Date	Prior Year Year-to-Date	Net Change Year-to-Date
Run: October 14, 2015 at 09:01 PM		Primary University	Primary University	Primary University
HCPC Contrac Allow-Medicare	41072	(3,209,693.37)	(2,627,679.24)	(582,014.13)
HCPC Contract Allow Medicaid	41073	(1,758,386.35)	(2,138,040.55)	379,654.20
HCPC Cont Allow Medicaid Mgd C	41074	(1,659,732.71)	(1,366,548.94)	(293,183.77)
HCPC Contr Allow Commercial	41075	(2,146,489.52)	(1,687,799.81)	(458,689.71)
HCPC Contr Allow Indigent Care	41076	(18,691,931.68)	(20,657,911.71)	1,965,980.03
HCPC Contr Allowances Other	41077	(12,768,824.62)	(12,138,807.14)	(630,017.48)
HCPC Bad Debt Recovery	41079	13,471.86	10,882.82	2,589.04
HCPC MHMR Revenues	41081	27,752,381.00	27,752,381.42	(0.42)
HCPC Medicare Part A	41083	338,848.28	169,636.44	169,211.84
HCPC Medicare Mgd Care Pt Svcs	41091	968,988.70	802,024.19	166,964.51
HCPC Self Pay Patient Services	41092	24,996,021.62	22,609,279.62	2,386,742.00
HCPC Other Govt Patient Svcs	41093	84,816.23	59,566.80	25,249.43
HCPC Cont Allow Medicare Mgd C	41094	(463,990.82)	(247,589.47)	(216,401.35)
HCPC Contr Allow Self Pay	41095	(24,950,028.19)	(22,577,211.40)	(2,372,816.79)
HCPC Contr Allow Other Govt	41096	(27,437.95)	(11,871.87)	(15,566.08)
Gain/Loss Sale Capital Assets	41602		(11,666.79)	11,666.79
Harris Cty Contract-HCPC	41700	3,464,777.00	3,545,272.69	(80,495.69)
Other Sources Non-Operating	41758		1,680,000.00	(1,680,000.00)
Tsf Within A Fund Class	55205	(2,515,430.52)	(1,566,679.48)	(948,751.04)
Faculty Salaries	67008	(4,726,800.90)	(4,280,977.40)	(445,823.50)
A&P Salaries	67010	(1,488,491.06)	(1,490,851.70)	2,360.64
Student Emp Salaries	67014	(26,805.28)		(26,805.28)
Classified Salaries	67015	(22,875,930.85)	(22,147,111.78)	(728,819.07)
Hazardous Duty Pay	67020	(3,480.00)	(5,530.00)	2,050.00
Overtime Pay	67021	(774,948.85)	(516,724.34)	(258,224.51)
Longevity Pay	67022	(394,360.76)	(390,108.68)	(4,252.08)
Vacation Benefits	67023	(349,616.73)	(333,802.90)	(15,813.83)
Shift Differential	67031	(1,078,190.05)	(1,033,194.53)	(44,995.52)
TRS Retirement Match (State)	67032	(1,838,269.95)	(1,790,166.35)	(48,103.60)
GRPI Insurance Benefits	67041	(3,407,358.39)	(3,108,990.05)	(298,368.34)
FICA Benefits - Matching	67043	(2,212,936.21)	(2,115,012.25)	(97,923.96)
UCI Benefits	67052	(49,311.10)	(54,849.97)	5,538.87
WCI Benefits	67061	(23,856.20)	(23,676.02)	(180.18)
ORP Retirement Matching	67086	(344,782.66)	(277,349.04)	(67,433.62)
Travel I/S- Public Transport	67101			
Travel I/S- Mileage	67102			
Travel I/S- Incidentals	67105			
Travel I/S- Meals/Lodg < \$80	67106			
Travel O/S- Public Transport	67111			
Travel O/S- Mileage	67112			
Travel O/S- Incidental Expense	67115			
Travel O/S- Mls/Lodg, Locality	67116	(2,00,4,00)	(4, 700, 00)	(4,500,00)
Membership Dues	67201	(3,284.00)	(1,722.00)	(1,562.00)
Tuition - Employee Training	67202	(2,533.41)	(13,036.00)	10,502.59
Registration Fees- Out of Town Insurance Premiums	67203 67204	(24.952.72)	(20,002,57)	2 220 95
Sales and Use Tax	67204	(34,853.72) 19.42	(38,093.57) 38.89	3,239.85 (19.47)
Fees And Other Charges	67210	(260,523.37)	(246,558.75)	(13,964.62)
Publications & Advertisements	67218	(1,045.00)	(3,385.26)	2,340.26
Credit Card Fees	67219	(571.48)	(966.41)	394.93
Consultant Services-Other	67240	(10,400.00)	(54,840.13)	44,440.13
Consultant Services-Computer	67242	(10,700.00)	(07,070.10)	
Educational/Training Services	67243	(26,130.38)	(20,964.20)	(5,166.18)
Financial/Acctng Services	67245	(29,123.18)	(26,890.91)	(2,232.27)
Medical Services	67248	(168,809.30)	(205,209.50)	36,400.20
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Run: October 14, 2015 at 09:01 PM		Primary University	Primary University	Primary University
Local mileage and parking	67250	(226.50)	(134.50)	(92.00)
Other Professional Services	67253	(1,388,493.09)	(1,369,713.04)	(18,780.05)
Architect/Engineering Services	67256	(1,300,493.09)	(1,509,715.04)	(10,700.03)
Maint & Repair- Comp Soft N/C	67262	(28,239.56)	(38,155.36)	9,915.80
Maint & Repair- Bldgs Non-Cap	67266	(399,930.21)	(270,764.82)	(129,165.39)
Maint & Repair- Comp Equip N/C	67267	(399,930.21)	(270,704.02)	(129,105.59)
Maint & Repair-Comp Equip N/C	67271			
Reproduction & Printing Svcs	67273	(41,599.16)	(40,449.24)	(1,149.92)
Temporary Employment Agencies	67274	(14,652.15)	(+0,++3.2+)	(14,652.15)
Computer Programming Services	67275	(346,709.13)	(372,372.85)	25,663.72
Cleaning Svcs/Uniform Rental	67277	(741,069.17)	(719,761.30)	(21,307.87)
Advertising Services	67281	(741,003.17)	(713,701.30)	(21,007.07)
Data Processing Services	67284			
Freight/Delivery Service	67286	(3,808.30)	(5,082.33)	1,274.03
Postal Expense	67291	(4,432.28)	(4,764.30)	332.02
Purchased Contract Services	67299	(4,402.20)	(348,272.92)	348,272.92
Consumable Supplies	67300	(121,749.01)	(122,968.55)	1,219.54
Subscript/Periodicals/Non-Libr	67303	(128.00)	(122,300.00)	(128.00)
Fuels & Lubricants	67304	(4,280.45)	(4,892.69)	612.24
Chemicals & Gases	67310	(178.60)	(4,032.03)	34.75
Medical Supplies	67312	(920,572.01)	(886,840.11)	(33,731.90)
Food Purchases	67315	(2,052.81)	(2,171.93)	119.12
Food Purch For Patients	67316	(1,741,488.48)	(1,632,628.13)	(108,860.35)
Supp/MatL- Ag,Hdwre,Construct	67328	(22,417.52)	(37,522.98)	15,105.46
Parts- Furnishings/Equipmt N/C	67330	(4,412.13)	(5,288.38)	876.25
Fabric And Linens	67333	(1,112110)	(8,762.00)	8,762.00
Furnishing & Equipment (N-Cap)	67334	(100,231.40)	(45,724.34)	(54,507.06)
Computer Parts (Non Capital)	67335	(3,519.39)	(469.59)	(3,049.80)
Building Improvements	67343	(-,)	()	(-,)
Leasehold Improvements	67344			
Maint & Repair- Furn/Eqpmt N/C	67367	(6,884.58)	(6,233.94)	(650.64)
Furnishings & Equipment (Cap)	67373	(5,312.00)	(39,926.33)	34,614.33
Furn & Equip (Controlled)	67374	(1,765.19)	(2,854.40)	1,089.21
Computer Equipment- Expensed	67377	(12,373.10)	(32,816.20)	20,443.10
Computer Equip (Controlled)	67378	(1,638.00)	(86,916.44)	85,278.44
Computer Equipment (Capital)	67379		(14,692.30)	14,692.30
Computer Software - Expensed	67380	(88,741.82)	(43,107.70)	(45,634.12)
Books & Reference Materials	67382	(1,350.29)	(2,596.02)	1,245.73
Computer Softw (DO NOT USE)	67387			
Books & Ref Material(Capital)	67389			
Inventory Purchased for Resale	67393			
Comp. Software-Purchased-Cap	67395			
Rental - Furnishings/Eqpmnt	67406	(75.00)	(75.00)	
Rental - Motor Vehicles	67442			
Rental - Space	67470	(24,923.13)	(27,378.00)	2,454.87
Utilities - Electricity	67501	(278,917.81)	(271,940.04)	(6,977.77)
Utilities - Natural Gas	67502	(29,909.95)	(23,441.49)	(6,468.46)
Telecomm-Long Dist	67503			
Telecomm-Monthly Chg	67504	(226,198.36)	(216,785.23)	(9,413.13)
Utilities - Water	67507	(100,082.71)	(100,876.75)	794.04
Telecomm-Maint/Repairs	67514	··	(1,680.50)	1,680.50
Telecomm-Other Svc Chgs	67516	(1,867.73)	(5,588.42)	3,720.69
Utilities - Waste Disposal	67526	(15,924.00)	(15,990.36)	66.36
Financial Services - Other	67643		(44,000,54)	44 000 54
Amortization Exp-Comp.Software	67878		(41,986.54)	41,986.54



Report ID: BSHCPC Report Layout: GLDM_BALSHEET_RV		Current Year Year-to-Date	Prior Year Year-to-Date	Net Change Year-to-Date
Run: October 14, 2015 at 09:01 PM		Primary University	Primary University	Primary University
Pers Prop/Depreciation Exp	67939		(201,329.25)	201,329.25
Dep Exp-Leasehold Improvements	67940		(29,979.57)	29,979.57
Dep Exp-Vehicles	67942		(6,252.85)	6,252.85
Non Mand Tsf Out to Plant	68209		(3,847,795.14)	3,847,795.14
Augmentation	69001	(509.76)	(141.63)	(368.13)
Faculty Salaries Non-Perm	69151	(27,400.00)	(32,200.00)	4,800.00
Classified Sal Non-Perm	69153	(385,264.34)	(374,105.64)	(11,158.70)
Certification Pay-Classified	69160	(4,300.00)	(7,445.00)	3,145.00
Premium Sharing Retirees	69206	(1,191,211.69)	(1,057,897.66)	(133,314.03)
Registration Fees - In Town	69210	(1,150.00)	(1,427.95)	277.95
Off Func - Employee Apprec.	69303			
Off Func - Recruitment	69304			
Tuition & Fees/Students	69312	(12,466.59)		(12,466.59)
Telecomm-Adds/Moves	69317	(3,386.89)	(19,531.01)	16,144.12
Other Contr Svces- Med Fdn Exp	69335	(941,414.34)	(714,402.94)	(227,011.40)
Locum Tenens Professional Serv	69338	(613,154.73)		(613,154.73)
Employee Relocation(Taxable)	69340			
Tenant Improvement Expense	69387		(37,858.00)	37,858.00
Patient CostsHCPC	69652	(7,212.64)	(4,491.75)	(2,720.89)
Return/Refund Fees	69702	(330.04)	(2,015.00)	1,684.96
FYE ADJUSTMENT	69801	(7,866.43)	17,311.69	(25,178.12)
M & O Accrual	69897	11,067.67	(14,365.96)	25,433.63
Statement of Revenue and Expense	-	(474,233.41)	679,017.90	(1,153,251.31)
Reserved for Encumbrances	-	(1,089,672.73)	(1,158,260.26)	68,587.53
TOTAL NET ASSETS	\$	6,980,086.21	8,401,667.11	(1,421,580.90)
TOTAL LIABILITIES AND NET ASSETS	\$	10,405,168.85	11,801,269.97	(1,396,101.12)



Balance Sheet-Desig Funds Dtl

As of August 31, 2015 Designated Funds - Fund Dtl

Capital Assets

Report ID: BSFDDESG Report Layout: GLDM_BALSHEET_RV Run: October 14, 2015 at 10:43 PM	_	Current Year Year-to-Date Primary University	Prior Year Year-to-Date Primary University	Net Change Year-to-Date Primary University
ASSETS	<u>Account</u>			
Current Assets:				
Cash & Cash Equivalents	- \$			
Restricted Cash & Cash Equivalents	-			
Balance in State Appropriations	-			
Funds Held by System Administration - Current	-	-		
Securities Lending Collateral	-	-		
Accounts Receivable, Net:				
Federal Receivables	-			
Other Intergovernmental Rec.	-			
Student Receivables	-			
Patient Receivables	-	43,118.59	63,283.31	(20,164.72)
Interest and Dividends	-			
Contributions Receivable	-			
Investment Trades	-	-		
Other Receivables	-	770.64		770.64
Federal Contracts and Grants	-			
Other Contracts and Grants	-			
Due From Other Funds	-	817,803.76	734,852.81	82,950.95
Due From System Administration	-			
Due From Other Components*	-			
Due From Other Agencies	-			
Inventories	-			
Loans and Contracts	-			
Other Current Assets				
Total Current Assets	\$	861,692.99	798,136.12	63,556.87
Restricted:				
Investments	- \$			
Loans, Contracts and Other	Ψ -			
Funds Held by System Administration	-			
Funds Held by System - Permanent Health Fund	-			
Funds Held by Sealy & Smith Foundation	_	_	_	_
Contributions Receivable	_			
Investments	_			
Other Non-Current Assets	_			

Less: Accumulated Depreciation	 -	-	-
Total Non-Current Assets			
TOTAL ASSETS	\$ 861,692.99	798,136.12	63,556.87

-

LIABILITIES				
Current Liabilities:				
Vouchers Payable	24000		25,085.47	(25,085.47)
Acct Payable-Received&Accrued	24016	191,208.37	153,457.98	37,750.39
Accrued Liabilities	24300	29.50	29.50	
Accounts Payable and Accrued Liabilities	- \$	191,237.87	178,572.95	12,664.92
Salaries Payables				
Federal Payables	-	-	-	-
Other Intergovernmental Payables	-	-	-	-
Investment Trades	-	-	-	-
Self-Insurance Claims IBNR	-	-	-	-
Securities Lending Obligations	-	-	-	-
Due to Other Funds	-			



Balance Sheet-Desig Funds Dtl As of August 31, 2015 Designated Funds - Fund Dtl

Report ID: BSFDDESG Report Layout: GLDM_BALSHEET_RV			Current Year Year-to-Date	Prior Year Year-to-Date	Net Change Year-to-Date
Run: October 14, 2015 at 10:43 PM			Primary	Primary	Primary
Due to System Administration			University	University	University
Due to System Administration Due to Other Components*	-				
Due to Other Agencies					
Deferred Revenue					
Employees' Compensable Leave-Current Portion	_				
Notes, Loans, and Lease Payable					
Revenue Bonds Payable-Current Portion	-		-	-	-
HEAF Bonds Payable-Current Portion	-		-	-	-
Funds Held for Others	-		-	-	-
Other Current Liabilities	-				
Clearing Account	-		5,498.51	5,976.49	(477.98)
Encumbrances	-		34,975.37	25,030.29	9,945.08
Total Current Liabilities		\$	231,711.75	209,579.73	22,132.02
		·			,
Non-Current Liabilities:					
Employees' Compensable Leave	-				
Assets Held for Others	-				
Held in Custody for Others	-				
Notes, Loans and Leases Payable	-				
Payable From Restricted Assets	-		-	-	-
Revenue Bonds Payable	-		-	-	-
HEAF Bonds Payable	-		-	-	-
Other Non-Current Liabilities	-				
Total Non-Current Liabilities					
TOTAL LIABILITIES		\$	231,711.75	209,579.73	22,132.02
NET ASSETS Invested in Capital Assets, Net of Related Debt Restricted for:		\$			
Nonexpendable					
Permanent University Fund Endowment True and Other Endowments, and Annuities	-		-	-	-
True and Other Endowments Held for Components					-
Expendable	-		-	-	-
Capital Projects	_		_		_
Debt Service	_		_	-	-
Funds Functioning as Endowment - Restricted	_		_	_	-
Funds Funct. as Endow - Restr. Held for Components	-		-	-	-
Other Expendable	-				
Unrestricted					
Fund Balance	-		613,586.68	468,674.46	144,912.22
Miscellaneous Income-Unres	41025		21,470.54	20,335.04	1,135.50
HCPC Medicare Patient Revenue	41066		557,233.00	606,932.00	(49,699.00)
HCPC Medicaid Patient Services	41067		267,631.00	340,600.00	(72,969.00)
HCPC Medicaid Mgd Care Pt Svcs	41068		473,559.00	500,325.00	(26,766.00)
HCPC Commercl Patient Services	41069		535,830.00	487,821.00	48,009.00
HCPC Indigent Care Pat Servs	41070		1,476,105.00	2,118,711.00	(642,606.00)
HCPC Other Patient Services	41071		1,175,813.00	1,155,747.00	20,066.00
HCPC Contrac Allow-Medicare	41072		(387,214.24)	(431,730.69)	44,516.45
HCPC Contract Allow Medicaid	41073		(215,263.41)	(262,577.59)	47,314.18
HCPC Cont Allow Medicaid Mgd C	41074		(312,688.82)	(345,400.93)	32,712.11
HCPC Contr Allow Commercial	41075		(399,499.14)	(403,901.38)	4,402.24
HCPC Contr Allow Indigent Care	41076		(1,476,104.20)	(2,118,671.68)	642,567.48
HCPC Contr Allowances Other	41077		(1,175,813.00)	(1,155,669.59)	(20,143.41)
HCPC Medicare Mgd Care Pt Svcs	41091		58,845.00	69,292.00	(10,447.00)
-					



Balance Sheet-Desig Funds Dtl

As of August 31, 2015 Designated Funds - Fund Dtl

Report ID: BSFDDESG Report Layout: GLDM_BALSHEET_RV		Current Year Year-to-Date	Prior Year Year-to-Date	Net Change Year-to-Date
Run: October 14, 2015 at 10:43 PM		Primary University	Primary University	Primary University
HCPC Self Pay Patient Services	41092	3,433,167.00	3,052,721.00	380,446.00
HCPC Other Govt Patient Svcs	41093	13,734.00	7,913.00	5,821.00
HCPC Cont Allow Medicare Mgd C	41094	(14,174.29)	(26,880.42)	12,706.13
HCPC Contr Allow Self Pay	41095	(3,413,818.55)	(3,014,011.47)	(399,807.08)
HCPC Contr Allow Other Govt	41096	(9,221.73)	(5,858.07)	(3,363.66)
Tsf UCP-Dept Dist&Assess	55204	(17,419.00)	(16,086.00)	(1,333.00)
Tsf Within A Fund Class	55205	2,142.10	1,010.02	1,132.08
Classified Salaries	67015	2,142.10	(300.00)	300.00
Vacation Benefits	67023	(2,293.48)	(1,352.84)	(940.64)
TRS Retirement Match (State)	67032	(2,739.42)	(3,665.72)	926.30
GRPI Insurance Benefits	67041	(5,705.15)	(4,533.21)	(1,171.94)
	67043	· · · · · · · · · · · · · · · · · · ·	(6,989.69)	
FICA Benefits - Matching		(12,638.99)		(5,649.30)
UCI Benefits	67052	(80.01)	(90.28)	10.27
WCI Benefits	67061	(155.70)	(95.78)	(59.92)
Employee Relocation	67071		(10,856.89)	10,856.89
ORP Retirement Matching	67086	(7,520.54)	(5,730.48)	(1,790.06)
Travel I/S- Public Transport	67101	(712.24)	(2,491.97)	1,779.73
Travel I/S- Mileage	67102	(1,347.29)	(1,729.39)	382.10
Travel I/S- Incidentals	67105	(797.05)	(695.02)	(102.03)
Travel I/S- Meals/Lodg < \$80	67106	(3,396.94)	(4,499.49)	1,102.55
Travel O/S- Public Transport	67111	(7,573.08)	(4,483.66)	(3,089.42)
Travel O/S- Mileage	67112	(584.25)	(487.65)	(96.60)
Travel O/S- Incidental Expense	67115	(2,300.29)	(1,912.39)	(387.90)
Travel O/S- Mls/Lodg, Locality	67116	(9,745.45)	(7,522.18)	(2,223.27)
Membership Dues	67201	(14,902.63)	(16,155.61)	1,252.98
Registration Fees- Out of Town	67203	(12,969.00)	(8,113.00)	(4,856.00)
Sales and Use Tax	67209	23.26	14.02	9.24
Fees And Other Charges	67210	(15,778.42)	(15,364.72)	(413.70)
Awards (To Employees)	67211		(498.00)	498.00
Consultant Services-Other	67240	(31,595.90)	(43,226.90)	11,631.00
Educational/Training Services	67243		(2,713.00)	2,713.00
Local mileage and parking	67250	(8,879.32)	(5,827.61)	(3,051.71)
Other Professional Services	67253	(35,376.17)	59,954.49	(95,330.66)
Maint & Repair- Bldgs Non-Cap	67266	(3.64)	(175.76)	172.12
Maint & Repair- Comp Equip N/C	67267	(210.00)		(210.00)
Reproduction & Printing Svcs	67273	(241.06)	(759.38)	518.32
Freight/Delivery Service	67286	(1,048.30)	(228.88)	(819.42)
Postal Expense	67291			
Purchased Contract Services	67299			
Consumable Supplies	67300	(10,540.95)	(2,884.54)	(7,656.41)
Subscript/Periodicals/Non-Libr	67303	(139.00)	(309.55)	170.55
Chemicals & Gases	67310	(287.38)		(287.38)
Medical Supplies	67312	(13,652.65)	(2,508.50)	(11,144.15)
Food Purchases	67315	(653.95)	(487.19)	(166.76)
Food Purch For Patients	67316	(48.48)	(151.41)	102.93
Supp/MatL- Ag,Hdwre,Construct	67328	(99.86)	(2.10)	(97.76)
Parts- Furnishings/Equipmt N/C	67330	()	(- /	
Plants (Purchased Only)	67331		(94.99)	94.99
Furnishing & Equipment (N-Cap)	67334	(39,943.31)	(2,556.50)	(37,386.81)
Computer Parts (Non Capital)	67335		(_,)	(01,000101)
Furnishings & Equipment (Cap)	67373	(23,366.94)		(23,366.94)
Computer Equipment- Expensed	67377	(661.20)	(120.20)	(541.00)
Computer Equip (Controlled)	67378	(001.20)	(120.20)	(00.140)
Computer Equipment (Capital)	67379			
Computer Software - Expensed	67380			
Computer Conware - Lypenseu	07300			



Balance Sheet-Desig Funds Dtl As of August 31, 2015 Designated Funds - Fund Dtl

Report ID: BSFDDESG Report Layout: GLDM_BALSHEET_RV		Current Year Year-to-Date	Prior Year Year-to-Date	Net Change Year-to-Date
Run: October 14, 2015 at 10:43 PM		Primary University	Primary University	Primary University
Books & Reference Materials	67382	(1,525.41)	(2,005.43)	480.02
Prsnl Prop - (CIP) - Fab Equip	67388	17,995.00	(17,995.00)	35,990.00
Rental - Furnishings/Eqpmnt	67406			
Rental - Space	67470			
Telecom Equipmnt Expensed	67517			
Travel- Non Employee	67562			
Texas State Sales Tax	67573	(54.44)	(3.64)	(50.80)
Interest On Delayed Payments	67806	(116.74)		(116.74)
Augmentation	69001	(128,818.22)	(121,031.46)	(7,786.76)
Incentive Payment	69163	(118,125.76)	(163,584.41)	45,458.65
Registration Fees - In Town	69210	(1,390.00)	(474.92)	(915.08)
Off Func - Academic Enrichment	69301	(3,200.00)	(4,500.00)	1,300.00
Off Func - Employee Apprec.	69303	(10,507.38)	(1,999.40)	(8,507.98)
Off Func - Development	69305	(20,012.90)	(13,141.03)	(6,871.87)
Off Func - Business Meetings	69308	(5,818.97)	(7,705.53)	1,886.56
Off Func - Off-Campus Bus Meet	69309	(240.00)	(120.00)	(120.00)
Travel - Recruiting(Taxable)	69341	, , ,	(3,063.50)	3,063.50
Travel-Vehicle Rental	69442	(262.76)	(266.73)	3.97
Return/Refund Fees	69702	(2,900.97)	(170.00)	(2,730.97)
Statement of Revenue and Expense	-	51,369.93	144,912.22	(93,542.29)
Reserved for Encumbrances	-	(34,975.37)	(25,030.29)	(9,945.08)
TOTAL NET ASSETS		\$ 629,981.24	588,556.39	41,424.85
TOTAL LIABILITIES AND NET ASSETS		\$ 861,692.99	798,136.12	63,556.87

Harris County Psychiatric Center (An Operating Unit of The University of Texas Health Science Center at Houston)

Independent Auditor's Report and Financial Statements

August 31, 2015 and 2014



Harris County Psychiatric Center (An Operating Unit of The University of Texas Health Science Center at Houston) August 31, 2015 and 2014

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Statements of Revenues and Expenses	3
Statements of Changes in Net Position	4
Notes to Financial Statements	5





Independent Auditor's Report

Governing Body Harris County Psychiatric Center (An Operating Unit of The University of Texas Health Science Center at Houston) Houston, Texas

We have audited the accompanying statements of revenues and expenses and changes in net position of Harris County Psychiatric Center, an operating unit of The University of Texas Health Science Center at Houston, Operating Fund 42000 and Practice Plan Fund 33076 and the statements of changes in net position of Harris County Psychiatric Center Plant Funds for Capital Improvement Projects for the years ended August 31, 2015 and 2014, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of statements of revenues and expenses and changes in net position that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the statements of revenues and expenses and changes in net position.



Governing Body Harris County Psychiatric Center (An Operating Unit of The University of Texas Health Science Center at Houston) Page 2

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the aforementioned financial statements referred to above present fairly, in all material respects, the revenues, expenses and changes in net position of Harris County Psychiatric Center, an operating unit of The University of Texas Health Science Center at Houston, Operating Fund 42000 and Practice Plan Fund 33076 and the changes in net position of the Harris County Psychiatric Center Plant Funds for Capital Improvement Projects for the years ended August 31, 2015 and 2014, in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 1, the financial statements of Harris County Psychiatric Center, an operating unit of The University of Texas Health Science Center at Houston, are intended to present the revenues, expenses and changes in net position for only the portion of the activities of The University of Texas Health Science Center at Houston that are attributable to the transactions of Operating Fund 42000, Practice Plan Fund 33076 and Plant Funds for Capital Improvement Projects of Harris County Psychiatric Center. They do not purport to, and do not present fairly, the revenues, expenses and changes in net position of Texas Health Science Center at Houston for the years ended August 31, 2015 and 2014, in accordance with accounting principles generally accepted in the University of America. Our opinion is not modified with respect to this matter.

BKD,LIP

Houston, Texas January 12, 2016

Harris County Psychiatric Center (An Operating Unit of The University of Texas Health Science Center at Houston) Statements of Revenues and Expenses Years Ended August 31, 2015 and 2014

	Fund 42000		Fund 33076		
	2015	2014	2015	2014	
Operating Revenues					
Net patient service revenue	\$ 7,086,500	\$ 8,015,838	\$ 588,120	\$ 575,360	
Contractual revenue	38,307,194	37,830,948	-	-	
State appropriations	6,479,589	6,044,923	-	-	
Other revenue	39,547	51,739	21,471	20,335	
Total operating revenues	51,912,830	51,943,448	609,591	595,695	
Operating Expenses					
Salaries and wages	31,786,479	30,278,395	246,944	284,915	
Employee benefits	9,417,344	8,850,615	31,133	22,458	
Purchased services and professional fees	3,343,947	2,886,493	31,596	43,227	
Overhead allocation	2,515,431	2,540,427	-	-	
Supplies and other	5,455,374	5,311,764	248,549	100,182	
Total operating expenses	52,518,575	49,867,694	558,222	450,782	
Operating Income (Loss)	(605,745)	2,075,754	51,369	144,913	
Nonoperating Revenues					
Investment income	131,514	124,954			
Excess (Deficiency) of Revenues Over Expenses Before Capital Appropriation	(474,231)	2,200,708	51,369	144,913	
Capital Appropriation - Texas Department of State Health Services		1,680,000			
Excess (Deficiency) of Revenues Over Expenses Before Capital Transfers	\$ (474,231)	\$ 3,880,708	\$ 51,369	\$ 144,913	

Harris County Psychiatric Center (An Operating Unit of The University of Texas Health Science Center at Houston) Statements of Changes in Net Position Years Ended August 31, 2015 and 2014

	Fund 42000	Fund 33076			Plant Funds		
Net Position, September 1, 2013	\$ 8,543,991	\$	468,675	\$	2,678,569		
Changes in Net Position							
Excess of revenues over expenses							
before capital transfers	3,880,708		144,913		-		
Transfers in (out)	(3,880,708)		-		3,880,708		
Transfers out for capital expenditures	 -		-		(2,785,137)		
Increase in Net Position	 0		144,913		1,095,571		
Net Position, August 31, 2014	 8,543,991		613,588		3,774,140		
Changes in Net Position							
Excess (deficiency) of revenues over expenses							
before capital transfers	(474,231)		51,369		-		
Transfers out for capital expenditures	 -		-		(1,059,360)		
Increase (Decrease) in Net Position	 (474,231)		51,369		(1,059,360)		
Net Position, August 31, 2015	\$ 8,069,760	\$	664,957	\$	2,714,780		

Note 1: Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations

Harris County Psychiatric Center (HCPC) is an operating unit of The University of Texas Health Science Center at Houston (the University), a division of the University of Texas System. HCPC provides inpatient psychiatric care to the residents of Harris County, Texas (the County), through an operating agreement with the Mental Health Mental Retardation Authority of Harris County (the Authority). Funding for these services is provided from patients, patient insurance carriers, contractual agreements with the Authority for indigent care, a contractual agreement with the Harris County Juvenile Probation Department (the Department) and State of Texas (the State) appropriations.

HCPC follows fund accounting with respect to its funds. The financial statements of HCPC include only the statements of revenues and expenses and changes in net position of Operating Fund 42000 and Practice Plan Fund 33076 and statements of changes in net position of Plant Funds for Capital Improvement Projects. The purpose of these funds is as follows:

- *Operating Fund 42000:* This fund accounts for the general operations of HCPC. Any change in net position, over an established operating reserve, is transferred to the Plant Funds for Capital Improvement Projects for use at HCPC.
- *Practice Plan Fund 33076:* This fund accounts for certain patient charges for professional services and related compensation and other expenses.
- Plant Funds for Capital Improvement Projects: Collectively comprised of the activity in Funds 26639, 26642, 26649, 26660, 26674, 26675 and 26680 for the year ended August 31, 2015, and Funds 26639, 26641, 26642, 26649, 26660 and 26661 for the year ended August 31, 2014. HCPC accumulates costs for each capital project utilizing a distinct fund number. These funds collectively account for capital improvement projects at HCPC. As funds are expended, the assets or capital project in service is transferred to a separate fund, which accounts for the capital assets of the University.

Basis of Presentation

The accompanying financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America as prescribed by the Governmental Accounting Standards Board.

The financial statements of HCPC have been prepared on the accrual basis of accounting using the economic resources measurement focus. Revenues and expenses from exchange and exchange-like transactions are recognized when the exchange transaction takes place, while those from government-mandated nonexchange transactions are recognized when all applicable

eligibility requirements are met. Operating revenues and expenses include exchange transactions; program-specific, government-mandated nonexchange transactions; and state appropriations for certain employee retirement and health insurance costs. Investment income is included in nonoperating revenues.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of net position and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Property and Equipment

Property and equipment acquisitions are recorded at the original cost. Capital projects are recorded at the original cost of construction, including capitalized project management fees from the University. Depreciation of capital assets is recorded based on an allocation from the University.

Net Patient Service Revenue

HCPC has agreements with third-party payers that provide for payments to HCPC at amounts different from its established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payers and others for services rendered and includes estimated retroactive revenue adjustments. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered and such estimated amounts are revised in future periods as adjustments become known. There were no retroactive adjustments recognized for the years ended August 31, 2015 and 2014.

Contractual Revenue

HCPC has three contractual agreements in place with the Authority to provide mental health and psychiatric services to the indigent population in the County: 1) Inpatient Services for Voluntary or Civil Commitment Process, 2) Inpatient Competency Restoration Services, and 3) Mental Health Inpatient Services.

HCPC also has a contractual agreement with the Department to provide a juvenile subacute program.

Revenue under these contractual agreements is recognized as the related services are rendered.

State Appropriations

HCPC receives appropriations from the State for certain employee retirement and health insurance costs as determined by the State legislature. These appropriations are reported as operating revenues in the accompanying financial statements.

Charity Care

HCPC provides charity care to patients who are unable to pay for services. The amount of charity care is included in net patient service revenue and is not separately classified from the provision for uncollectible accounts.

Risk Management

HCPC is exposed to various risks of loss from torts; theft of, damage to and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; medical malpractice; and employee health, dental and accident benefits. Chapter 101 of the Texas Civil Practice and Remedies Code provides HCPC indemnification by the State in an amount up to \$250,000 per claim. HCPC is self-insured for a portion of its exposure to risk of these losses.

Reclassifications

Certain reclassifications have been made to the 2014 financial statements to conform to the 2015 financial statement presentation. These reclassifications had no effect on the change in net position.

Note 2: Net Patient Service Revenue

HCPC has agreements with third-party payers that provide for payments to HCPC at amounts different from its established rates. These payment arrangements include:

Medicare: Inpatient psychiatric services rendered to Medicare program beneficiaries are paid at prospectively determined rates under the Medicare Inpatient Psychiatric Facility Prospective Payment System. These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors. HCPC is reimbursed for

certain services at tentative rates with final settlement determined after submission of annual cost reports by HCPC and audits thereof by the Medicare administrative contractor.

Medicaid: Inpatient psychiatric services rendered to Medicaid program beneficiaries are paid at prospectively determined per diem rates that are based on the patients' acuity. HCPC is reimbursed for cost reimbursable services at tentative rates with final settlement determined after submission of annual cost reports by HCPC and audits thereof by the Medicaid administrative contractor.

Approximately 45 percent and 51 percent of net patient service revenue is from participation in the Medicare and state-sponsored Medicaid programs for the years ended August 31, 2015 and 2014, respectively. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation and change. As a result, it is reasonably possible that recorded estimates will change materially in the near term.

HCPC has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for payment to HCPC under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

Note 3: Related-party Transaction

HCPC leases a jointly owned facility from the State and the County for \$1 per year.

Note 4: Interfund Capital Transfers

During 2015 and 2014, HCPC Operating Fund 42000 transferred \$0 and \$3,880,708, respectively, of its excess (deficiency) of revenues over expenses to the Plant Funds for Capital Improvement Projects under the terms of its operating agreement with the Authority. This interfund capital transfer is used to fund capital improvement projects at the HCPC facility. Upon expenditure of these funds, the Plant Funds for Capital Improvement Projects transfers any assets or construction in progress to a fund outside of the Plant Funds for Capital Improvement Projects. As a result, no depreciation expense is recorded in the Plant Funds for Capital Improvement Projects.

The following projects were funded, net of related rebates, for the years ended August 31.

Project Number	Fund	Project Description	2015		5 201	
HDM12-3	26639	Renovation and Improvements of 11 Patient				
		Units: Unit 1B Currently Under Renovation	\$	91,618	\$	632,296
HDM12-4	26639	HVAC3: Above Ceiling Air Duct Replacement				
		and Digital Controls, 11 Patient Units Areas		89,982		215,269
HDM15-3	26641	HCPC Building Envelope Plaza Deck				
		Renovation		-		76,419
HDM15-4	26642	Refurbishment and Field Installation of				
		Switchgear for Emergency Generator		7,966		38,891
HDM15-1	26649	HCPC HVAC4 AHU and Exhaust Fan				
		Replacement		189,554		1,346,184
MIS	26661	Network Refresh: replacement of network				
		switches; replacement and upgrades of UPS				
		equipment; increased switchport count; and				
		replacement and additional access points for				
		wireless coverage		-		476,078
HDM15-7	26660	Patient Monitoring System		315,000		-
HDM15-8	26674	HCPC Unit 2B Renovation		51,750		-
HDM15-9	26675	HCPC Unit 2D Renovation		138,187		-
HDM16-0	26680	HCPC Sunrise 15.1 Upgrade		175,303		-
			\$	1,059,360	\$	2,785,137

Note 5: Significant Estimates and Concentrations

Accounting principles generally accepted in the United States of America require disclosure of certain significant estimates and current vulnerabilities due to certain concentrations. Those matters include the following:

Allowance for Net Patient Service Revenue Adjustments

Estimates of allowances for adjustments included in net patient service revenue are described in Notes 1 and 2.

Concentrations

Approximately 69 percent of HCPC's operating revenues for each of the years ended August 31, 2015 and 2014, were from contractual arrangements with the Authority.

Note 6: Pension Plans

Teacher Retirement System (TRS)

The State has joint contributory retirement plans for substantially all of its employees. One of the primary plans in which the University participates is a cost-sharing multi-employer defined benefit pension plan administered by the TRS of Texas. TRS is primarily funded through State and employee contributions. Depending upon the source of funding for a participant's salary, the University may be required to make contributions in lieu of the State.

All University personnel employed in a position on a half time or greater basis for at least $4\frac{1}{2}$ months or more are eligible for membership in the TRS retirement plan. Members with at least five years of service have a vested right to unreduced retirement benefits at age 65 or provided they have a combination of age plus years of service totaling 80 or more. However, members who began TRS participation on or after September 1, 2007, must be age 60 to retire and members who are not vested in TRS on August 31, 2014, must be age 62 to retire under the second option.

Members are fully vested after five years of service and are entitled to any reduced benefits for which the eligibility requirements have been met prior to meeting the eligibility requirements for unreduced benefits.

TRS contribution rates for both employers and employees are not actuarially determined but are legally established by the State Legislature. Contributions by employees are 6.4 percent of gross earnings. Depending upon the source of funding for the employee's compensation, the State or University contributes a percentage of participant salaries totaling 6.4 percent of annual compensation for 2015, 2014 and 2013. Contributions to TRS for the years ended August 31, 2015, 2014 and 2013, were \$1,841,009, \$1,793,458 and \$1,609,441, respectively, for the HCPC operating unit, which equaled the amounts of the required contributions for those years.

No liability is recorded at the HCPC operating unit level as the liability is recorded by the University of Texas System as the ultimate employer. Further information regarding actuarial assumptions and conclusions, together with audited financial statements, are included in the TRS annual financial report, which may be found on the TRS website at www.trs.state.tx.us.

Optional Retirement Program (ORP)

The State has also established an ORP for institutions of higher education. Participation in the ORP is in lieu of participation in the TRS. ORP is available to certain eligible employees who hold faculty positions and other professional positions, as defined. The ORP provides for the purchase of annuity contracts and mutual funds. Participants are vested in the employer contributions after one year and one day of service. Depending upon the source of funding for the employee's compensation, the University may be required to make the employer contributions

in lieu of the State. Since these are individual annuity contracts, the State and University have no additional or unfunded liability for this program. The employee and employer contribution rates are established by the State Legislature each biennium. The State provides an option for a local supplement on top of the State base rate. Each institution within the University of Texas System can decide to adopt and fund a local supplement each year to provide each ORP employee the maximum employer rate. The Chancellor of the University of Texas System then approves the employer rates each fiscal year. The contributions made by participants (6.65 percent of annual compensation) and the University (6.60 percent State base rate for 2015, 2014 and 2013 plus any local supplement for a maximum 8.50 percent of annual compensation) for the fiscal years ended August 31, 2015, 2014 and 2013. Contributions to ORP for the years ended August 31, 2015, 2014 and 2013, were \$352,304, \$283,079 and \$301,886, respectively, for the HCPC operating unit.

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