Health Financial Systems In Lieu of Form CMS-2552-10 FLOYD MEMORIAL HOSPITAL & HEALTH SVS This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 Worksheet S Parts I-III Date/Time Prepared: 5/31/2016 9:07 am HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 150044 Period: From 01/01/2015 AND SETTLEMENT SUMMARY 12/31/2015 То PART I - COST REPORT STATUS 1.[X]Electronically filed cost report Date: 5/31/2016 9:07 am Provider Time: 2.[use only]Manually submitted cost report]If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 0 3.[4. [F 6. Date Received: Contractor 1]Cost Report Status 10.NPR Date: 5. F

 (1) As submitted
 7. Contractor No.
 11. Contractor's Vendor Code:
 4

 (2) Settled without Audit 8. [N] Initial Report for this Provider CCN
 11. Contractor's Vendor Code:
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 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN
 11. Contractor's Vendor Code:
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 use only (3) Settled with Audit (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FLOYD MEMORIAL HOSPITAL & HEALTH SVS (150044) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. Encryption Information (Signed) 4 ECR: Date: 5/31/2016 Time: 9:07 am Administrator of Provider(s) or pJCeU8IsQJNXmZcQnwD5Tt37Be8gI0 :qdptOv.UhuBsarUmVu1EfUIdWwIEp 20801SvWNI0UH7SP Title Date: 5/31/2016 Time: 9:07 am PT: pAl11Le5ZeaWulvyXobYVHq1RBsvw0 01yab0T4JUJ52Ot00KcXsXqw.1Dzzu Date zUdK0q0fjf0gIfrk Title XVIII Part B Title V Part A HIT Title XIX 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1.00 0 -128,046 179.777 36.048 0 1.00 Hospital Subprovider - IPF 0 0 2.00 2.00 0 0 Subprovider - IRF 3.00 0 0 0 0 3.00 4.00 SUBPROVIDER I 0 0 0 0 4.00 5.00 0 0 0 0 5.00 Swing bed - SNF 6.00 6.00 Swing bed - NF 0 0 0 0 7.00 SKILLED NURSING FACILITY 0 0 7.00 8.00 NURSING FACILITY 0 0 8.00 0 0 0 0 9.00 9.00 HOME HEALTH AGENCY I 0 10.00 10.00 RURAL HEALTH CLINIC I 0 0 11.00 FEDERALLY QUALIFIED HEALTH CENTER I 0 0 0 11.00 12.00 CMHC I 0 0 0 12.00 179,777 0 200.00 200.00 Total 0 -128,046 36,048 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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00	for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in col um 1, this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	October 1. Enter in reporting period occ requires final und ? (see instructions he cost reporting period of the portion of the portion 2, "Y" for yes or "N" dicaid days on lind f census days, or "N" dicaid days in column t unpaid days	n column curring compensa s) Enter eriod pr n of the "N" for (see in ds (as c for no. es 24 an 3 if dat period d <u>enter "</u> n-State Medicaid aid days <u>1.00</u> 2,166	1 2, "Y" on or a ited car- in col ior to cost re cost r cost re cost re cost re cost re cost re cost re d/or 25 conted ifferen Y" for In-St Medic eligi unpa day 2.0 6 2	for yes fter Oct e paymer umn 1, " October eporting rural a in FY2C porting the port ons) Doe in accor below? scharge. t from t yes or " ate 0 aid 5 ble Me id pai s 0 , 779	s or "N" cober 1. hts to be Y" for y 1. Enter period as a resu D15? Ente period cion of t es this rdance wi In colum Is the che metho N" for n ut-of State di cai d d days 3.00 123	es on It N r he th n d o. Out-of 1 State H Medicaid el igible unpaid 4.00 139	4MO day 5.00	d C ys Med 0 248	I I I I I I I I I I I I I I I I I I I	22. 22. 23. 23.

			ITAL & HEALTH S			ו Lieu	u of Form		
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ΑΤΑ	Provi der		eriod: rom 01/01/ p 12/31/		Workshe Part I Date/Ti 5/27/20	me Pre	pared:
					Urban/Rur 1.00		Date of	Geogr	
26.00	Enter your standard geographic classification (not w			ginning of the		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 en or rural. If a	d of the cost pplicable,		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 ı 2. 0		-
36.00	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		Subscript line	36 for number				-	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of perio	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 of enter subsequent dates.								38.00
					Y/N 1.00		Y/I 2. 0		-
39.00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i						N		39.00
40.00	or "N" for no. Does the facility meet the mileage re CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo	equireme or "N" on adjus ober 1.	nts in accorda for no. (see tment? Enter " Enter "Y" for	nce with 42 instructions) Y" for yes or	N		Y		40.00
	no in column 2, for discharges on or after October 1	. (see	instructions)			V	XVIII	XI X	
	Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
45.00	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	ent for	di sproporti ona	te share in ac	cordance	N	Y	N	45.00
46.00	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
	Is this a new hospital under 42 CFR §412.300 PPS cap Is the facility electing full federal capital paymer Teaching Hospitals					N N	N N	N N	47.00 48.00
56.00	Is this a hospital involved in training residents in	approv	ed GME program	s? Enter "Y"	for yes	N			56.00
57.00	or "N" for no. 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	or "N" for no i his cost repor	n column 1. lf ting period?	column 1 Enter "Y"				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	l, if a nburseme	pplicable. ent for physici						58.00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If ye	s, 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"	for ye	s or "N" for n	o. (see instru	<u>ctions)</u>	N			60.00
		Y/N	I ME	Direct GME	IME		Di rect		
61.00	Did your hospital receive FTE slots under ACA	1.00 N	2.00	3.00	4.00	0.00	5.0		61.00
61 01	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care		0.00	0.00					61.01
01.01	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00					01.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of	2	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 determining compliance with the 75% test. (see		0. OC	0.00					61.03
61.04	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 1.04 minute line (1.02) (see instructions)	2	O. OC	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

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DA	ATA	Provi der		Period:	Worksheet S-2	
					From 01/01/2015 To 12/31/2015	Part I Date/Time Pre 5/27/2016 2:5	
		Progra	n Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. (00	2.00	3.00	4.00	
 Of the FTEs in line 61.05, specify specialty, if any, and the number for each new program. (see instru- column 1, the program name, enter program code, enter in column 3, unweighted count and enter in colu- FTE unweighted count. Of the FTEs in line 61.05, specification 	of FTE residents ctions) Enter in in column 2, the the IME FTE umn 4, direct GME				0.00		61.1
program specialty, if any, and the residents for each expanded progr- instructions) Enter in column 1, enter in column 2, the program co 3, the IME FTE unweighted count at 4, direct GME FTE unweighted count	e number of FTE am. (see the program name, de, enter in column nd enter in column				0.00	0.00	01.2
						1.00	
ACA Provisions Affecting the Heal							
2.00 Enter the number of FTE residents	2		this cost	reporting pe	riod for which	0.00	62.0
your hospital received HRSA PCRE 2.01 Enter the number of FTE residents during in this cost reporting per	that rotated from a iod of HRSA THC prog	a Teaching gram. (see	instructic		o your hospital	0.00	62.0
3.00 Has your facility trained residen "Y" for yes or "N" for no in colu	ts in nonprovider se	ettings dur	ing this c	1 3		N	63.0
				Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				Site 1.00	2.00	3.00	
Section 5504 of the ACA Base Year	FTE Residents in N	onprovi der	Settings				
period that begins on or after Ju				-			
4.00 Enter in column 1, if line 63 is the number of the base year period, the number resident FTEs attributable to roth settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1)	er of unweighted nor ations occurring in number of unweighted r hospital. Enter in	n-primary c all nonpro d non-prima n column 3	are vider ry care the ratio	0.0	0 0.00	0. 000000	64.0
	Program Name	Progra	n Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2. (00	3.00	4.00	5.00	
5.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column				0.0	0 0.00	0. 000000	65.0

Health Financial Systems		EMORIAL HOSPITAL				u of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH	CARE COMPLEX IDENTIFICAT	ION DATA	Provi der		eriod: com 01/01/2015 o 12/31/2015	Worksheet S-2 Part I Date/Time Pre 5/27/2016 2:5	pared:
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	A Current Year FTE Reside	ents in Nonprovide	er Setting	1.00 gsEffective f	2.00 For cost report	3.00 ing periods	
Enter in column 2 the n FTEs that trained in yo	number of unweighted non- otations occurring in all number of unweighted non- our hospital. Enter in co	nonprovider sett primary care resi lumn 3 the ratio	i ngs. dent	0.00	0.00	0. 000000	66.00
(column 1 divided by (c	column 1 + column 2)). (s Program Nam		Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.0	C	3.00	4.00	5.00	
67.00 Enter in column 1, the name associated with earyour primary care prograwhich you trained reside Enter in column 2, the code. Enter in column 3 number of unweighted pricare FTE residents attrite to rotations occurring non-provider settings. column 4, the number of unweighted primary care resident FTEs that trai your hospital. Enter in 5, the ratio of (column 3 + 4)). (see instructions)	program ach of ams in dents. program 3, the imary ributable in all Enter in e ned in n column 1 3 column			0.00			67.00
					1.00	0 2.00 3.00	
Inpatient Psychiatric F					4	5 2.00 3.00	
70.00 Is this facility an Inp Enter "Y" for yes or "N		ity (IPF), or doe	s it cont	ain an IPF sub	provider? N		70.00
recent cost report file 42 CFR 412.424(d)(1)(ii program in accordance w Column 3: If column 2 i (see instructions)	1: Did the facility have ed on or before November i)(c)) Column 2: Did thi vith 42 CFR 412.424 (d)(1 s Y, indicate which prog	15, 2004? Enter s facility train)(iii)(D)? Enter	"Y" for y residents "Y" for y	es or "N" for in a new teac es or "N" for	no. (see hi ng no.	0	71.00
75.00 Is this facility an Inp		cility (IRF), or	does it c	ontain an IRF	N		75.00
subprovider? Enter "Y" 76.00 If line 75 yes: Column recent cost reporting p no. Column 2: Did this CFR 412.424 (d)(1)(iii)	' for yes and "N" for no	an approved GME e November 15, 20 in a new teachin r "N" for no. Col	teaching 04? Enter g program umn 3: If	program in the "Y" for yes o in accordance column 2 is Y	r "N" for with 42	0	76.00
	year began during this e	ost reporting per	100. (300		I	1.00	
Long Term Care Hospital 80.00 Is this a long term car 81.00 Is this a LTCH co-locat "Y" for yes and "N" for	re hospital (LTCH)? Ente ted within another hospit				period? Enter	NN	80. 00 81. 00
TEFRA Providers 85.00 Is this a new hospital 86.00 Did this facility estab \$413.40(f)(1)(ii)2 Ent		ider (excluded un				N	85. 00 86. 00
87.00 Is this hospital a "sub for yes or "N" for no.	oclause (II)" LTCH classi	fied under sectio	n 1886(d)	(1)(B)(iv)(II)	? Enter "Y"	N	87.00
					V 1.00	XI X 2.00	
Title V and XIX Service		tiont hoonital oo	m. (nton "V" for			00.00
90.00 Does this facility have yes or "N" for no in th	ne applicable column.	·			N	Y	90.00
	"Y" for yes or "N" for n	o in the applicab	Ie column	I.	N	Y	91.00
92.00 Are title XIX NF patien instructions) Enter "Y"	nts occupying title XVIII ' for yes or "N" for no i			ion)? (see		N	92.00
93.00 Does this facility oper		for purposes of t		d XIX? Enter	N	N	93.00
94.00 Does title V or XIX red applicable column.			"N" for n	o in the	Ν	N	94.00

Health Financial Systems FLOYD MEMORIAL HOSPITAL & HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider		In Lie	u of Form C Worksheet	
		rom 01/01/2015	Part I Date/Time	Prepared:
		V	5/27/2016 XI X	
95.00 If line 94 is "Y", enter the reduction percentage in the applicable colur 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for r applicable column.		1.00 0.00 N	2.00 0 (N	0. 00 95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the applicable colur Rural Providers	nn.	0.0		0. 00 97. 00
105.00 Does this hospital qualify as a critical access hospital (CAH)? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive met for outpatient services? (see instructions)	thod of payment	N N		105.00 106.00
 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the preimbursed. If yes complete Wkst. D-2, Pt. II. 	tructions) lf	N		107.00
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee sche CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
Physi cal 1.00	Occupational 2.00	Speech 3.00	Respirato 4.00	bry
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.				109.00
			1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstrati the current cost reporting period? Enter "Y" for yes or "N" for no.	on project (41	OA Demo)for	N	110.00
Miscellaneous Cost Reporting Information		1.0	0 2.00 3.	00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no i is yes, enter the method used (A, B, or E only) in column 2. If column 2 3 either "93" percent for short term hospital or "98" percent for long te psychiatric, rehabilitation and long term hospitals providers) based on t	is "E", enter erm care (inclu	in column des		0 115.00
Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "1 117.00 Is this facility legally-required to carry malpractice insurance? Enter ' no.		"N" for Y		116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1	if the policy	is 1		118.00
claim-made. Enter 2 if the policy is occurrence.	Premi ums	Losses	Insuranc	e
	1.00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:	1, 488, 144			0118.01
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 schedule listing of and amounts contained therein. 119.00D0 NOT USE THIS LINE	cost centers			119.00
120.00 s this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, " "N" for no. Is this a rural hospital with < 100 beds that qualifies for 1 Hold Harmless provision in ACA §3121 and applicable amendments? (see inst Enter in column 2, "Y" for yes or "N" for no.	Y" for yes or the Outpatient	N	N	120.00
121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. Transplant Center Information	es charged to	Y		121.00
125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N	'forno.lf	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certi in column 1 and termination date, if applicable, in column 2.	fication date			126.00
127.00 If this is a Medicare certified heart transplant center, enter the certified heart transplant center, en	fication date			127.00
128.00 If this is a Medicare certified liver transplant center, enter the certified	fication date			128.00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certificolumn 1 and termination date, if applicable, in column 2.	cation date in			129.00
130.00 If this is a Medicare certified pancreas transplant center, enter the cendate in column 1 and termination date, if applicable, in column 2.	rti fi cati on			130.00
131.00 If this is a Medicare certified intestinal transplant center, enter the order of the first state of the state of th	certi fi cati on			131.00
132.00 If this is a Medicare certified islet transplant center, enter the certified	fication date			132.00
in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter the certification of the	fication date			133.00
in column 1 and termination date, if applicable, in column 2. 134.00 If this is an organ procurement organization (OPO), enter the OPO number and termination date, if applicable, in column 2.	in column 1			134.00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	FLOYD MEMORIAL EX IDENTIFICATION DAT/		& HEALTH S Provider (In Lieu /01/2015 2/31/2015	u of Form CMS- Worksheet S-2 Part I Date/Time Pre	pared:
								5/27/2016 2:5	2 pm
							1. 00	2.00	1
All Providers 140.00 Are there any related organizatio chapter 10? Enter "Y" for yes or	"N" for no in column	1. If yes	and home	office c			N		140.00
are claimed, enter in column 2 th	<u>e home office chain n</u>	<u>umber. (s</u> 2.00	ee instruct	tions)			3.00		
If this facility is part of a cha	in organization, ente		s 141 throu	ugh 143 t	the nam	ne an		of the home	
office and enter the home office 141.00Name:	<u>contractor name and c</u> Contractor's Nar		number.	Contr	actor'	c Nu	mbor:		141.00
141. 00 street:	PO Box:	lie.		Contr	actor	Sivui	ilber.		141.00
143. 00 Ci ty:	State:			Zip (Code:				143.00
								1.00	-
144.00 Are provider based physicians' co	sts included in Works	heet A?						Y	144.00
145.00 If costs for renal services are c	laimed on Wkst A li	no 74 an	a the costs	for			1.00 N	2.00	145.00
inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N"	" for yes or "N" for clude Medicare utiliz for no in column 2.	no in col ation for	umn 1. lfc this cost	column 1 reportin	ıg				
146.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	n column 1. (See CMS	reviously Pub. 15-2	chapter 4	t report? 40, §4020)) f		N		146.00
								1.00	-
147.00 Was there a change in the statist								N	147.00
148.00Was there a change in the order o 149.00Was there a change to the simplif					for n	0		N	148.00 149.00
147. oolidas there a change to the shipirri	rea cost frinding meth		Part A	Part			tle V	Title XIX	147.00
			1.00	2.00			3.00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or									
155. 00Hospi tal			N	N			N	N	155.00
156.00 Subprovi der – IPF			N	N			N	N	156.00
157. 00 Subprovi der – IRF 158. 00 SUBPROVI DER			N	N			Ν	N	157.00 158.00
159. 00 SNF			N	N			Ν	Ν	159.00
160.00 HOME HEALTH AGENCY			N	N			N	N	160.00
161.00CMHC 161.10CORF				N N			N N	N N	161.00
		I	1						
Mul ti compus								1.00	
Multicampus 165.00 s this hospital part of a Multic	ampus hospital that h	as one or	more campu	uses in d	li ffere	ent CE	BSAs?	N	165.00
Enter "Y" for yes or "N" for no.									
	Name 0		unty . 00	State 2.00			CBSA 4.00	FTE/Campus 5.00	-
166.00 fline 165 is yes, for each	0		. 00	2.00	0.0		4.00		166.00
campus enter the name in column									
0, county in column 1, state in column 2, zip code in column 3,									
CBSA in column 4, FTE/Campus in									
column 5 (see instructions)									
								1.00	-
Health Information Technology (HI	T) incentive in the A	merican R	ecovery and	d Reinves	stment	Act			
167.00 Is this provider a meaningful use								Y	167.00
168.00 If this provider is a CAH (line 1 reasonable cost incurred for the			user (IIIIe	8 107 15	¥),	enter	the	(168.00
168.01 If this provider is a CAH and is	not a meaningful user	, does th				haro	lshi p		168.01
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful						I" \ ·	ntor the	0.05	169.00
transition factor. (see instructi) anu isi	iot a CAH (0 IS N	،), e	enter the	0.25	109.00
							ji nni ng	Endi ng	
170.00 Enter in columns 1 and 2 the EHR	beginning date and en	ding date	for the re	eporting			1.00 01/2015	2.00 06/30/2015	170.00
period respectively (mm/dd/yyyy)	seg. In the date and en	ang date	. or the re	-poi ting		547	., 2010	00,00,2010	

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Health Financial Systems	FLOYD MEMORIAL HOSPITAL	& HEALTH SVS	In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I DENTIFICATION DATA	Provider CCN: 150044	Period: From 01/01/2015 To 12/31/2015		epared:
				1.00	
171.00 If line 167 is "Y", does this provi- Medicare cost plans reported on Wks (see instructions)				Ν	171.00

Health Financial Syste

FLOYD MEMORIAL HOSPITAL & HEALTH SVS

In Lieu of Form CMS_2552_10

		MEMORIAL HOSPITAL & HEALTH			eu of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ESTI ONNAI RE Provi der	F	eriod: rom 01/01/2015 o 12/31/2015	5 Date/Time Pre	epared:
		i		Y/N	5/27/2016 2:5 Date	p2 pm
				1.00	2.00	
	General Instruction: Enter Y for all YES res mm/dd/yyyy format.	ponses. Enter N for all NO m	responses. Ente	r all dates in	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
1.00	Has the provider changed ownership immediate reporting period? If yes, enter the date of			N		1.00
		¥	Y/N	Date	V/I	
2.00	llos the provider terminated participation in	the Medicare Dreaman? If	1.00 N	2.00	3.00	2.00
2.00	Has the provider terminated participation in yes, enter in column 2 the date of terminati voluntary or "I" for involuntary.		N			2.00
3.00	Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are relate officers, medical staff, management personne of directors through ownership, control, or relationships? (see instructions)	., chain home offices, drug d to the provider or its 1, or members of the board	N			3.00
			Y/N	Туре	Date	
			1.00	2.00	3.00	-
4.00	Financial Data and Reports Column 1: Were the financial statements pre Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Compiled, enter date available in	Y	A		4.00
5.00	column 3. (see instructions) If no, see inst Are the cost report total expenses and total those on the filed financial statements? If	revenues different from	N			5.00
		<i>,,</i>	1	Y/N	Legal Oper.	
				1.00	2.00	
6.00	Approved Educational Activities Column 1: Are costs claimed for nursing sch the legal operator of the program?	ool? Column 2: If yes, is	the provider is	N		6.00
7.00	Are costs claimed for Allied Health Programs	? If "Y" see instructions.		Ν		7.00
8.00	Were nursing school and/or allied health pro	grams approved and/or renew	ed during the	N		8.00
0.00	cost reporting period? If yes, see instructi			N		
9.00	Are costs claimed for Interns and Residents program in the current cost report? If yes,		cal education	N		9.00
10.00	Was an approved Intern and Resident GME prog	ram initiated or renewed in	the current	Ν		10.00
11.00	cost reporting period? If yes, see instructi Are GME cost directly assigned to cost cente Teaching Program on Worksheet A? If yes, see	rs other than I & R in an Ap	oproved	Ν		11.00
					Y/N 1.00	
10.00	Bad Debts				Y	1 1 0 00
12.00 13.00	Is the provider seeking reimbursement for ba If line 12 is yes, did the provider's bad de period? If yes, submit copy.			st reporting	Y N	12.00 13.00
14.00	If line 12 is yes, were patient deductibles Bed Complement				N	14.00
15.00	Did total beds available change from the pri	or cost reporting period? It			N	15.00
		Description	Y/N	t A Date	Part B Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
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		N		N	16.00
17.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is		Y	04/05/2016	Y	17.00
18. 00	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		Ν		N	18.00
19. 00	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		Ν		N	19.00
20. 00	instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

Heal th	Financial Systems FLOYD	MEMORIAL HOSP	PITAL & HEALTH	SVS	In Lie	u of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Period:	Worksheet S-	2
					From 01/01/2015 To 12/31/2015		epared.
						5/27/2016 2:	
					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		5	N 1.00	2.00	3.00	21.00
	provider's records? If yes, see						
	instructions.						
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPI	TALS ONLY (EXC	EPT CHILDRENS I	HOSPI TALS)		1.00	
	Capital Related Cost						
	Have assets been relifed for Medicare purpos				ng the east		22.00 23.00
23.00	Have changes occurred in the Medicare deprec reporting period? If yes, see instructions.	ration expense	due to apprais	sais made duri	ng the cost		23.00
24.00	Were new leases and/or amendments to existin	g Leases enter	ed into during	this cost rep	orting period?		24.00
	lf yes, see instructions	-					
25.00	Have there been new capitalized leases enter instructions.	ed into during	the cost repo	rting period?	lf yes, see		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acq	uired during t	he cost report	ing period? If	yes, see		26.00
27.00	instructions. Has the provider's capitalization policy cha	naed during th	e cost reportiu	na period? If	ves submit		27.00
27.00	copy.	nged during th		ng period. II	yes, submit		27.00
	Interest Expense						
28.00	Were new Loans, mortgage agreements or lette period? If yes, see instructions.	rs of credit e	ntered into du	ring the cost	reporting		28.00
29.00	Did the provider have a funded depreciation	account and/or	bond funds (D	ebt Service Re	eserve Fund)		29.00
	treated as a funded depreciation account? If						
30.00	Has existing debt been replaced prior to its instructions.	scheduled mat	urity with new	debt? If yes,	see		30.00
31.00	Has debt been recalled before scheduled matu	rity without is	ssuance of new	debt? If yes,	see		31.00
	instructions.	-					_
32 00	Purchased Services Have changes or new agreements occurred in p	atient care se	rvices furnish	ed through cor	tractual		32.00
02.00	arrangements with suppliers of services? If			eu thiough coi			02.00
33.00	If line 32 is yes, were the requirements of	Sec. 2135.2 ap	plied pertaini	ng to competit	ive bidding? If	-	33.00
	no, see instructions. Provider-Based Physicians						_
	Are services furnished at the provider facil	itv under an a	rrangement wit	h provider-bas	ed physicians?		34.00
	lf yes, see instructions.	5	0				
35.00	If line 34 is yes, were there new agreements physicians during the cost reporting period?			nts with the p	orovi der-based		35.00
		· ·			Y/N	Date	
	llema Office Costa				1.00	2.00	_
36 00	Home Office Costs Were home office costs claimed on the cost r	eport?					36.00
	If line 36 is yes, has a home office cost st	•	repared by the	home office?			37.00
38.00	If yes, see instructions.	of the home of	flag different	from that of			38.00
36.00	If line 36 is yes, was the fiscal year end the provider? If yes, enter in column 2 the						36.00
39.00	If line 36 is yes, did the provider render s						39.00
40.00	see instructions. If line 36 is yes, did the provider render s	anyloge to the	home office?	lf.voc coo			40.00
40.00	instructions.	ervices to the	nome office?	TT yes, see			40.00
	Cost Poport Proparor Contact Information		1.	00	2.	00	
41.00	Cost Report Preparer Contact Information Enter the first name, last name and the title	e/position	BKD, LLP		BKD, LLP		41.00
	held by the cost report preparer in columns						
40.00	respectively.						40.00
42.00	Enter the employer/company name of the cost preparer.	report	BKD, LLP				42.00
43.00	Enter the telephone number and email address		502-581-0435		LVCOSTREPORTS@	BKD. COM	43.00
	report preparer in columns 1 and 2, respecti	vel y.	l				

Heal th	Financial Systems FLOYD	MEMORIAL HOSPI	TAL & HEALTH	SVS	In Lieu	ı of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 150044	Period:	Worksheet S-	2
						Part II Date/Time Pro	anarod
					10 12/31/2013	5/27/2016 2:	
		Part B			·		
		Date					
		4.00					
	PS&R Data						_
16.00	Was the cost report prepared using the PS&R						16.00
	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						
47.00	instructions)	04/05/004/					17.00
17.00	Was the cost report prepared using the PS&R	04/05/2016					17.00
	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)						
18 00	If line 16 or 17 is yes, were adjustments						18.00
10.00	made to PS&R Report data for additional						10.00
	claims that have been billed but are not						
	included on the PS&R Report used to file						
	this cost report? If yes, see instructions.						
19.00	If line 16 or 17 is yes, were adjustments						19.00
	made to PS&R Report data for corrections of						
	other PS&R Report information? If yes, see						
	instructions.						
20.00	If line 16 or 17 is yes, were adjustments						20.00
	made to PS&R Report data for Other? Describe						
	the other adjustments:						
21.00	Was the cost report prepared only using the						21.00
	provider's records? If yes, see						
	instructions.						
		_		00			
	Cost Depart Droppers Contact Information		3	. 00			
41 00	Cost Report Preparer Contact Information Enter the first name, last name and the title		KD, LLP				41.00
41.00	held by the cost report preparer in columns		NU, LLM				41.00
	respectively.	1, 2, and 3,					
40.00	Fatar the analysis (company, some of the cost of						12.00

- 42.00 Enter the employer/company name of the cost report
- 43.00 Enter the telephone number and email address of the cost report preparer.
 43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.

42.00

43.00

	CARE COMPLEX STATISTIC	AL DATA	Provid	der		Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part I Date/Time Pre 5/27/2016 2:5	pared
Component		Worksheet A Line Number	No. of Be	ds	Bed Days Avai I abl e	CAH Hours	I/P Days / O/P Visits / Trips Title V	
	-	1.00	2.00		3.00	4.00	5.00	
.00 Hospital Adults & Peds 8 exclude Swing Bed, 0 Hospice days)(see inst for the portion of LDP 2.00 HM0 and other (see ins 8.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds	bservation Bed and ructions for col. 2 room available beds) tructions)	30.00	2.00	195	71, 17		0	2. (3. (4. (5. (
.00 Hospital Adults & Peds .00 Total Adults and Peds. .00 Total Adults and Peds. .00 beds) (see instruction	. Swing Bed NF (exclude observation			195	71, 17	5 0.00	0	6. 7.
3.00INTENSIVE CARE UNIT2.00CORONARY CARE UNIT10.00BURN INTENSIVE CARE UNIT11.00SURGICAL INTENSIVE CARE UNIT12.00OTHER SPECIAL CARE (SP13.00NURSERY14.00Total (see instruction15.00CAH visits16.00SUBPROVIDER - IPF17.00SUBPROVIDER - IRF18.00SUBPROVIDER - IRF18.00SUBPROVIDER19.00SKILLED NURSING FACILITY21.00OHER LONG TERM CARE22.00HOME HEALTH AGENCY23.00AMBULATORY SURGICAL CE24.10HOSPICE24.10HOSPICE25.10CMHC - CMFC26.00RURAL HEALTH CLINIC26.00RURAL HEALTH CLINIC26.00Ambulance Trips30.00Employee discount days31.00Employee discount days32.00Labor & delivery days32.01Total ancillary labor	IT E UNIT ECIFY) s) TY NTER (D.P.) part) ALTH CENTER -26) (see instruction) - IRF (see instructions)	31. 00 32. 00 33. 00 34. 00 43. 00 41. 00 42. 00 44. 00 45. 00 101. 00 115. 00 116. 00 30. 00 99. 10 88. 00 89. 00		16 0 0 2111 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	77, 01	0.00 0.00 0.00		14.0 15.0 16.0 17.0 20.0 21.0 22.0 23.0 24.0 24.0 25.0 25.0 26.0 26.0 27.0

	Financial Systems FLOYD AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der		Period: From 01/01/2015 To 12/31/2015		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
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)	26, 512	1, 886	50, 73	2		1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	6, 284 0	6, 089 0				2.00 3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF	0 0	0		0		4.00 5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)	26, 512	0 1, 886		0 2		6.00 7.00
8.00 9.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	2, 494	178 0	4, 80	0		8.00 9.00
10.00 11.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0	1	0		10.00
12.00 13.00	OTHER SPECIAL CARE (SPECIFY) NURSERY	0	102	2, 75			12.00 13.00
13.00 14.00 15.00	Total (see instructions) CAH visits	29, 006	2, 166	58, 28		2, 191. 88	
16.00	SUBPROVIDER - IPF	0	0	1	0 0.00		16.00
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER	0	0		0 0.00 0 0.00	0.00	18.00
19.00 20.00	SKILLED NURSING FACILITY NURSING FACILITY	0	0 0		0 0.00 0 0.00		
21.00 22.00	OTHER LONG TERM CARE HOME HEALTH AGENCY	20, 489	0		0 0.00 6 0.00		
23.00 24.00	AMBULATORY SURGI CAL CENTER (D. P.) HOSPI CE	o	0		0.00		
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	0	0		0 0 0.00	0.00	24.10 25.00
25.10 26.00	CMHC - CORF RURAL HEALTH CLINIC	0	0		0 0.00 0 0.00	0.00	25.10
26.00 26.25 27.00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0	0		0 0.00 0.00 0.00	0.00	26.25
28.00 29.00	Observation Bed Days Ambulance Trips	0	679	9, 02		2,202.21	28.00 29.00
30.00 31.00	Employee discount days (see instruction) Employee discount days - IRF				0		30.00 31.00
32. 00 32. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room	0	304	71	0		32.00 32.01
33.00	outpatient days (see instructions) LTCH non-covered days	о					33.00

SPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provi der		Period: From 01/01/2015 To 12/31/2015		parec
	Full Time Equivalents		Di so	harges		
Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Workers				Patients	
	11.00	12.00	13.00	14.00	15.00	
 November 2015 November 2015		C C C C C C C C	6, 46 1, 34 6, 46	0 470 2 1, 439 0 0	13, 292	15. 16. 17. 18. 19. 20.

Heal th	Financial Systems	FLOYD	MEMORIAL HOSP	PITAL & HEALTH	SVS	In Lie	u of Form CMS-2	2552-10
	AL WAGE INDEX INFORMATION				CCN: 150044 P F	eriod: rom 01/01/2015 o 12/31/2015	Worksheet S-3 Part II	pared:
		Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet A-6)	Sal ari es (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARIES							-
1.00	Total salaries (see	200.00	137, 011, 277	C	137, 011, 277	4, 642, 996. 05	29. 51	1.00
2.00	instructions) Non-physician anesthetist Part A		0	C	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part		0	C	0	0.00	0.00	3.00
4.00	B Physician-Part A - Administrative		0	C	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	C	0	0.00	0.00	4.01
5.00	Physician-Part B		0	C	0	0.00		
6.00	Non-physician-Part B		0	C	0	0.00		
7.00	Interns & residents (in an approved program)	21.00	0			0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved		0	С	0	0.00	0.00	7.01
8.00	programs) Home office personnel		0	C	0	0.00		
9. 00 10. 00	SNF Excluded area salaries (see	44.00	0 50, 993, 008	 	0 50, 884, 215	0. 00 1, 375, 273. 47	0. 00 37. 00	
	instructions) OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		358, 196	C	358, 196	16, 509. 32	21. 70	11.00
12.00	Contract Labor: Top Level management and other management and administrative		0	С	0	0. 00	0. 00	12.00
13.00	services Contract Labor: Physician-Part A - Administrative		106, 850	C	106, 850	772.00	138. 41	13.00
14.00	Home office salaries & wage-related costs		0	C	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	C	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	С	0	0.00	0.00	16.00
17.00	WAGE-RELATED COSTS Wage-related costs (core) (see		20, 301, 671	C	20, 301, 671			17.00
18.00	instructions) Wage-related costs (other) (see instructions)		0	C	0			18.00
19.00	Excluded areas		8, 912, 904	0	8, 912, 904			19.00
20.00	Non-physician anesthetist Part A		0	C	0			20.00
21.00	Non-physician anesthetist Part B		0	C	0			21.00
22.00	Physician Part A - Administrative		0	(C	0			22.00
22.01	Physician Part A - Teaching		0	C	0			22.01
23.00	Physician Part B Wage-related costs (RHC/FQHC)		0		-			23.00
24.00 25.00	Interns & residents (in an approved program)		0		-			24.00 25.00
26.00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	<u>-S</u> 4.00	3, 988, 222	C	3, 988, 222	62, 738. 33	40 E7	26.00
28.00 27.00 28.00	Administrative & General Administrative & General	4.00 5.00	3, 966, 222 10, 527, 795 656, 024	81, 816		387, 651. 37	27.37	
_3.00	contract (see inst.)		220, 024			5, 557. 52	100.40	
29.00	Maintenance & Repairs	6.00	0	C	0	0.00		29.00
30.00	Operation of Plant	7.00	1, 825, 246		.,			30.00
31.00 32.00	Laundry & Linen Service Housekeeping	8.00 9.00	90, 148 1, 552, 444		90, 148 1, 552, 444			31.00 32.00
32.00 33.00	Housekeeping Housekeeping under contract (see instructions)	9.00	1, 552, 444 9, 003		9,003			32.00
34.00 35.00	Dietary Dietary under contract (see	10.00	1, 848, 045 0	C	1, 848, 045 0	127, 631. 26 0. 00		34.00 35.00
36.00	i nstructi ons) Cafeteri a	11.00	0	c	0	0.00	0.00	36.00
37.00 38.00	Maintenance of Personnel Nursing Administration	12.00 13.00	0 0	-		0.00 0.00	0.00	37.00 38.00

Health Financial Systems FLOYD MEMORIAL HOSPITAL & HEALTH SVS In Lieu						u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2015	Worksheet S-3 Part II	
					To 12/31/2015		
	Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
	Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
			(from	3)	col. 4	col. 5)	
			Worksheet				
			A-6)				
	1.00	2.00	3.00	4.00	5.00	6.00	
39.00 Central Services and Supply	14.00	1, 069, 298	B 0	1, 069, 29	8 66, 235. 64	16. 14	39.00
40.00 Pharmacy	15.00	3, 167, 330	0	3, 167, 33	0 74, 151. 38	42.71	40.00
41.00 Medical Records & Medical	16.00	3, 944, 957	0	3, 944, 95	7 154, 065. 64	25.61	41.00
Records Library							
42.00 Social Service	17.00	C	0		0.00	0.00	42.00
43.00 Other General Service	18.00	C	0		0.00	0.00	43.00

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Heal th	Financial Systems	FLOYD	MEMORIAL HOSE	PITAL & HEALTH	SVS	In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2015	Worksheet S-3 Part	
						To 12/31/2015	Date/Time Pre 5/27/2016 2:5	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				-		
1.00	Net salaries (see		137, 676, 304	0	137, 676, 30	4, 649, 995. 32	29.61	1.00
	instructions)							
2.00	Excluded area salaries (see		50, 993, 008	-108, 793	50, 884, 21	5 1, 375, 273. 47	37.00	2.00
2 00	instructions)		0/ /02 20/	100 700	0/ 702 00	0 0 074 701 05	24 50	2.00
3.00	Subtotal salaries (line 1 minus line 2)		86, 683, 296	108, 793	86, 792, 08	3, 274, 721. 85	26.50	3.00
4.00	Subtotal other wages & related		465, 046	0	465, 04	6 17, 281. 32	26, 91	4.00
1.00	costs (see inst.)		100,010		100, 01	0 17,201.02	20.71	1.00
5.00	Subtotal wage-related costs		20, 301, 671	0	20, 301, 67	0.00	23.39	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		107, 450, 013	108, 793	107, 558, 80	6 3, 292, 003. 17	32.67	6.00
7.00	Total overhead cost (see		28, 678, 512	81, 816	28, 760, 32	8 1, 097, 006. 51	26. 22	7.00
	instructions)							

	Financial Systems FLOYD MEMORIAL HOSP AL WAGE RELATED COSTS	PITAL & HEALTH SVS Provider CCN: 15		u of Form CMS-2 Worksheet S-3	
HUSPII	AL WAGE RELATED COSTS	Provider CCN: 15	0044 Period: From 01/01/2015	Part IV	
			To 12/31/2015	Date/Time Pre 5/27/2016 2:5	
				Amount	2 pm
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETI REMENT COST			-	
1.00	401K Employer Contributions			0	1
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			1, 619, 153	
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0	
4.00	Qualified Defined Benefit Plan Cost (see instructions)			3, 133, 436	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			1	
5.00	401K/TSA Plan Administration fees			0	
6.00	Legal /Accounting/Management Fees-Pension Plan			0	0.00
7.00	Employee Managed Care Program Administration Fees			0	7.00
	HEALTH AND INSURANCE COST				
3.00	Health Insurance (Purchased or Self Funded)			15, 384, 836	
9.00	Prescription Drug Plan			0	
10.00	Dental, Hearing and Vision Plan			551, 067	
11.00	Life Insurance (If employee is owner or beneficiary)			-202, 612	
12.00	Accident Insurance (If employee is owner or beneficiary)			0	-
13.00	Disability Insurance (If employee is owner or beneficiary)			289, 483	
	Long-Term Care Insurance (If employee is owner or beneficia	ary)		0	
15.00	'Workers' Compensation Insurance			316, 395	
16.00	Retirement Health Care Cost (Only current year, not the ex	traordinary accrual r	equired by FASB 106.	0	16.00
	Non cumulative portion) TAXES				
17 00	FICA-Employers Portion Only			7 001 ((0	17.00
10.00	Medicare Taxes - Employers Portion Only			7, 881, 668	17.00
	Unemployment Insurance			74,404	
	State or Federal Unemployment Taxes			74,404	
20.00	OTHER			0	20.00
21 00	Executive Deferred Compensation (Other Than Retirement Cos	t Poportod on Linos 1	through 4 above (see	• 0	21.00
21.00	instructions))	t Reported on Thes T	through 4 above. (See	# 0	21.00
22 00	Day Care Cost and Allowances			0	22.00
	Tuition Reimbursement			166, 745	
	Total Wage Related cost (Sum of lines 1 -23)			29, 214, 575	
2 7. 00	Part B - Other than Core Related Cost			27,214,373	27.00
	OTHER WAGE RELATED COSTS (SPECIFY)				25.00

	Financial Systems	TEOTO MEMORIAE 1103	PITAL & HEALTH SVS		u of Form CMS-2	
HUSPII	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150044	Period: From 01/01/2015	Worksheet S-3 Part V	
					Date/Time Pre	pared
				10 12/01/2010	5/27/2016 2:5	
	Cost Center Description			Contract	Benefit Cost	
				Labor		
				1.00	2.00	
	PART V - Contract Labor and Benefit Co	ost				
	Hospital and Hospital-Based Component	I denti fi cati on:				
1.00	Total facility's contract labor and b	enefit cost		0	0	1.00
2.00	Hospi tal			0	0	2.00
3.00	Subprovider - IPF			0	0	3.00
4.00	Subprovider - IRF			0	0	4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF			0	0	8.00
9.00	Hospital-Based NF			0	0	9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA			0	0	11.00
12.00	Separately Certified ASC			0	0	12.00
13.00	Hospital-Based Hospice			0	0	13.00
14.00	Hospital-Based Health Clinic RHC			0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			0	0	15.00
16.00	Hospital-Based-CMHC			0	0	16.00
16. 10	Hospital-Based-CMHC 10			0	0	16. 10
17.00	Renal Dialysis			0	0	17.00
18.00	Other			0	0	18.00

	2	MEMORIAL HOSP	ITAL & HEALTH	SVS	In Lie	u of Form CMS-2	2552-10
HOME H	EALTH AGENCY STATISTICAL DATA			F	Period: From 01/01/2015		
			Componen	t CCN: 157152 T	To 12/31/2015 Home Health	Date/Time Pre 5/27/2016 2:5 PPS	pared: 2 pm
					Agency I	PPS	
						00	
0.00	County	T	T		FLOYD	T . I . I	0.00
		<u>Title V</u> 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00		4.00	5.00	
1.00	Home Health Aide Hours	0	2, 558	192	1, 306	4, 056	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1, 346. 00				2.00
				Number of Empl	oyees (Full Ti	me Equivalent)	
		Enter the numb		n Staff	Contract	Total	
		your normal	work week				
		0)	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	I	40.00		0.00	0.00	2 00
3.00 4.00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40. OC	0.00			
5.00	Other Administrative Personnel			12.79			
6.00	Direct Nursing Service			16. 76	0.00	16. 76	6.00
7.00	Nursi ng Supervi sor			0.00			
8.00 9.00	Physical Therapy Service			6. 19 0. 00			
	Physical Therapy Supervisor Occupational Therapy Service			1. 79			
	Occupational Therapy Supervisor			0.00			
	Speech Pathology Service			0. 73			
	Speech Pathology Supervisor			0.00			
	Medical Social Service			0. 12			
15.00 16.00	Medical Social Service Supervisor Home Health Aide			0.00			
17.00	Home Heal th Aide Supervisor			0.00			
18.00	Other (specify)			0.00			
	HOME HEALTH AGENCY CBSA CODES	1		-		I	
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost			5			19.00
	reporting period.						
20.00	List those CBSA code(s) in column 1 serviced			31140			20.00
	during this cost reporting period (line 20						
20. 01	contains the first code).			50031			20.01
20.01				50031			20.01
20.02				50040			20.02
20.04				99915			20.04
		Full Ep Without			PEP Only	Tatal (asla	
		Outliers		LUPA Epi sodes	Epi sodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA					10.755	
21.00	Skilled Nursing Visits Skilled Nursing Visit Charges	10, 108					
22.00 23.00	Physical Therapy Visits	1, 943, 010 5, 122	37, 915 20			2, 065, 685 5, 324	
	Physical Therapy Visit Charges	968, 450					
25.00	Occupational Therapy Visits	1, 508	11	10	28	1, 557	25.00
	Occupational Therapy Visit Charges	278, 980	2,035				
27.00 28.00	Speech Pathology Visits Speech Pathology Visit Charges	387 71, 865		-		397 73, 715	
	Medical Social Service Visits	63	3	925			
	Medical Social Service Visit Charges	13, 860	660				
31.00	Home Health Aide Visits	2, 264			30		
32.00	Home Health Aide Visit Charges	181, 120	9, 760				
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	19, 452	359	431	247	20, 489	33.00
34.00	Other Charges	23, 419	656	312	72	24, 459	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28,	3, 480, 704					
	30, 32, and 34)						
36.00	Total Number of Episodes (standard/non	1, 325		173	22	1, 520	36.00
37.00	outlier) Total Number of Outlier Episodes		8	3	0	8	37.00
	Total Non-Routine Medical Supply Charges	69, 862					

Heal th	Financial Systems FLOYD MEMORIAL HOSPITAL	& HEALTH S	VS	In Lie	u of Form CMS-2	2552-10
		Provider (CCN: 150044	Period:	Worksheet S-1	0
				From 01/01/2015		
				To 12/31/2015		
					5/27/2016 2:5	2 pm
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by Li	ne 202 colum	n 8)	0. 230477	1.00
1.00	Medicaid (see instructions for each line)	ded by III		11 0)	0.230477	1.00
2.00	Net revenue from Medicaid				12, 542, 038	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental	payments	from Medicai	d?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from	Medi cai d			0	5.00
6.00	Medi cai d charges				100, 406, 307	6.00
7.00	Medicaid cost (line 1 times line 6)				23, 141, 344	7.00
8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 min	us sum of li	nes 2 and 5; if	10, 599, 306	8.00
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instructi	ons for ea	ach line)			
9.00	Net revenue from stand-al one SCHIP				0	9.00
10.00	Stand-al one SCHIP charges				0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			16 +h	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (, i i ne i i m	inus iine 9;	IT < Zero then	0	12.00
	enter zero) Other state or local government indigent care program (see instr	uctions f	or oach line)		
13.00	Net revenue from state or local indigent care program (Not inclu				0	13.00
14.00	Charges for patients covered under state or local indigent care				517, 873	
14.00					517,075	14.00
15.00	State or local indigent care program cost (line 1 times line 14)				119, 358	15.00
16.00	Difference between net revenue and costs for state or local indi		program (li	ne 15 minus line		
	13; if < zero then enter zero)	5				
	Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to fur	5	5		0	
18.00	Government grants, appropriations or transfers for support of ho				7, 310	
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local	i ndi gent	care progra	ms (sum of lines	10, 718, 664	19.00
	8, 12 and 16)				T b b c b d	
			Uni nsured	Insured	Total (col. 1	
		+	patients 1.00	patients 2.00	+ col. 2) 3.00	
20.00	Total initial obligation of patients approved for charity care (at full	1, 662, 79			20.00
20.00	charges excluding non-reimbursable cost centers) for the entire		1,002,7	0, 770, 422	10,000,214	20.00
21.00	Cost of initial obligation of patients approved for charity care		383, 23	2, 067, 476	2, 450, 711	21.00
	times line 20)	,				
22.00	Partial payment by patients approved for charity care		25, 63	103, 149	128, 784	22.00
23.00	Cost of charity care (line 21 minus line 22)		357,60	1, 964, 327	2, 321, 927	23.00
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patient		nd a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care p					
	If line 24 is "yes," charges for patient days beyond an indiger		ogram's leng	th of stay limit		25.00
26.00						
27.00	Medicare bad debts for the entire hospital complex (see instruct				754, 412	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (lir			o 20)	25, 657, 369	•
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	ense (IIne	I LIMES IIN	e 28)	5, 913, 433	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	20)			8, 235, 360	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus lir	ie 30)			18, 954, 024	31.00

	Financial Systems FLOYE SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (D MEMORIAL HOSPI DF EXPENSES		CCN: 150044 Pe	eri od:	u of Form CMS-2 Worksheet A	2552-10
				Fi To	rom 01/01/2015 0 12/31/2015	Date/Time Pre	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)		5/27/2016 2:5 Reclassified Trial Balance	
				+ (01. 2)	A-6)	(col. 3 +-	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	GENERAL SERVICE COST CENTERS	1					
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		8, 906, 017 9, 967, 145	8, 906, 017 9, 967, 145	262, 844 0	9, 168, 861 9, 967, 145	1.00 2.00
3.00	00300 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	3, 988, 222 10, 527, 795	1, 747, 198 29, 636, 916		-2, 751 174, 436	5, 732, 669 40, 339, 147	4.00 5.00
6.00	00600 MAI NTENANCE & REPAI RS	0	27,030,710	0	0	40, 337, 147	6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 825, 246 90, 148	5, 089, 831 923, 276	6, 915, 077 1, 013, 424	0	6, 915, 077 1, 013, 424	7.00
9.00	00900 HOUSEKEEPI NG	1, 552, 444	1, 034, 261		0	2, 586, 705	9.00
10.00	01000 DI ETARY	1, 848, 045	1, 788, 011	3, 636, 056	0	3, 636, 056	
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	11.00
13.00	01300 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	1, 069, 298 3, 167, 330	1, 783, 987 14, 068, 993		182, 589- 12, 953, 696-		14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	3, 944, 957	1, 453, 403		12, 755, 070	5, 398, 360	
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
30.00	03000 ADULTS & PEDIATRICS	18, 599, 594	9, 110, 093	27, 709, 687	76, 188	27, 785, 875	30.00
31.00	03100 INTENSIVE CARE UNIT	2, 683, 720	962, 744		-224, 254	3, 422, 210	31.00
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	32.00 33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	34.00
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0	0	0	0	41.00
43.00	04300 NURSERY	0	0	0	950, 666	950, 666	43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0	0	0	44.00 45.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
50.00	ANCILLARY SERVICE COST CENTERS	6, 872, 256	17, 971, 977	24, 844, 233	-14, 254, 384	10, 589, 849	50.00
51.00	05100 RECOVERY ROOM	0, 072, 250	0	24, 844, 233	-14, 254, 384	10, 589, 849	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 921, 299	1, 189, 342	4, 110, 641	-2, 516, 964	1, 593, 677	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 7, 521, 715	0 7, 470, 988	0 14, 992, 703	0 -1, 397, 334	0 13, 595, 369	53.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00 57.00	05600 RADI 0I SOTOPE 05700 CT SCAN	0 538, 056	0 710, 804	0 1, 248, 860	0 167, 753-	0 1, 081, 107	56.00 57.00
58.00	05800 MRI	354, 067	377, 325		-133, 477	597, 915	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 366, 020	9, 957, 064		-9, 580, 365		
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	3, 527, 076 0	7, 108, 979 0	10, 636, 055 0	-31, 080 0	10, 604, 975 0	60.00 60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM		0	0	0	0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD 06300 BLOOD STORING PROCESSING & TRA	0	0	0	0	0	62.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	451, 419	11, 344, 790	11, 796, 209	-11, 165, 388	-	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 899, 585 2, 725, 849	909,090		-216, 339		65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	2,723,649	1, 751, 449 0	4, 477, 298 0	12, 629 0	4, 489, 927 0	67.00
68.00	06800 SPEECH PATHOLOGY	204, 814	70, 952		0	275, 766	68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	1, 933, 114 60, 782	1, 315, 706 18, 778		-9, 272 6	3, 239, 548 79, 566	69.00 70.00
70.01	07001 SLEEP DI SORDER	688, 929	241, 846	930, 775	-967	929, 808	70.01
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PAT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12, 242, 593 16, 494, 391	12, 242, 593 16, 494, 391	
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23, 971, 214		
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75.00 76.00	07500 ASC (NON-DI STINCT PART) 03950 NUTRI TI ON/DI ABETES		0 0		0 0	0	75.00
76.97	07697 CARDI AC REHABI LI TATI ON	359, 538	156, 660	516, 198	-188	516, 010	
88.00	OUTPATIENT SERVICE COST CENTERS	o	0	0	0	0	88.00
88.00 89.00	08800 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00
90.00	09000 CLI NI C	445, 374	1, 103, 037		-378, 843		90.00
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT	3, 851, 577	1, 715, 000	5, 566, 577	-498, 382	5, 068, 195	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS	н — — — — — — — — — — — — — — — — — — —		I			1
94.00 95.00		0	0 0		0	0	94.00 95.00
95.00 96.00	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	1
	016 2:52 pm C:\MCRIF32\Floyd2015.mcrx	. I		- I			·

Health Financial Systems FLOYE	D MEMORIAL HOSPI	TAL & HEALTH	SVS	In Lie	u of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der		Period:	Worksheet A	
				From 01/01/2015 To 12/31/2015	Date/Time Pre	nared
				10 12/31/2013	5/27/2016 2:5	
Cost Center Description	Sal ari es	Other		Recl assi fi cat		
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	07.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	(0 0	0	
99.00 09900 CMHC	0	0	(0 0	0	
99. 10 09910 CORF	0	0	(0 0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	(0 0		100.00
101.00 10100 HOME HEALTH AGENCY	2, 782, 686	1, 154, 965	3, 937, 65	0	3, 937, 651	101.00
SPECIAL PURPOSE COST CENTERS						105 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	(0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	(0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0	(0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0	(0		108.00
109.00 10900 PANCREAS ACQUISITION	0	0	(0		109.00
110.00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	(0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	(0		111.00
113.00 11300 I NTEREST EXPENSE		0	(0		113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF	0	0	(0		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	(0		115.00
116.00 11600 HOSPI CE		151 040 (07		0 470 041		116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	88, 800, 955	151, 040, 627	239, 841, 58	470, 941	240, 312, 523	118.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN		0			0	190.00
190.00 19000 GTFT FLOWER COFFEE SHOP & CAN 191.00 19100 RESEARCH	47, 797	12, 406	60, 203		60, 203	
191.00 19100 RESEARCH 192.00 19200 PHYSI CLANS PRI VATE OFFI CES	36, 133, 180	12, 400	48, 761, 46		48, 761, 461	
192. 01 19200 PHISICIANS PRIVATE OFFICES	460, 448	5, 101, 077			5, 561, 525	•
192. 02 19201 UTHER NRCC	11, 346, 870	17, 801, 734			29, 148, 604	
193. 00 19300 NONPALD WORKERS	11, 340, 870	17, 801, 734	29, 140, 004			192.02
194. 00 07950 MARKETI NG	222, 027	1, 384, 611	1, 606, 63	5	1, 135, 697	
200.00 TOTAL (SUM OF LINES 118-199)	137, 011, 277	187, 968, 736			324, 980, 013	
200.00 10TAL (30M 01 LINES 110-199)	137,011,277	107, 700, 730	324, 700, 01,	ט וי	524, 700, 013	1200.00

			To 12/31/20	015 Date/Time Prepare 5/27/2016 2:52 pm
Cost Center Description	Adjustments	Net Expenses		572772016_2:52_pf
	(See A-8)	For		
	6.00	Allocation 7.00		
GENERAL SERVICE COST CENTERS	0,00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	I	
0 00100 CAP REL COSTS-BLDG & FIXT	0			1
0 00200 CAP REL COSTS-MVBLE EQUIP	0			2
0 00300 OTHER CAP REL COSTS	0	C 5 371 033		3
00 00400 EMPLOYEE BENEFITS DEPARTMENT 00 00500 ADMINISTRATIVE & GENERAL	-361, 636 -12, 684, 656			4
0 00600 MAI NTENANCE & REPAI RS	-12,004,030	27,034,471		6
0 00700 OPERATION OF PLANT	-4, 118	6, 910, 959		7
0 00800 LAUNDRY & LINEN SERVICE	0	1, 013, 424		8
0 00900 HOUSEKEEPI NG	0	2, 586, 705		9
00 01000 DI ETARY	-1, 229, 859			10
00 01100 CAFETERIA 00 01200 MAINTENANCE OF PERSONNEL	0			11
00 01300 NURSI NG ADMI NI STRATI ON	0			13
00 01400 CENTRAL SERVICES & SUPPLY	-29, 037	2, 641, 659		14
00 01500 PHARMACY	-597, 402			15
00 01600 MEDICAL RECORDS & LIBRARY	0			16
00 01700 SOCIAL SERVICE	0	0		
INPATIENT ROUTINE SERVICE COST CENTERS 00 03000 ADULTS & PEDIATRICS	2 550 047	25, 227, 028		30
00 03100 INTENSIVE CARE UNIT	-2, 558, 847			30
00 03200 CORONARY CARE UNIT	0	0, 422, 210		32
00 03300 BURN I NTENSI VE CARE UNI T	0	0		33
00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		34
00 04000 SUBPROVIDER - IPF	0	0		40
00 04100 SUBPROVI DER - I RF 00 04200 SUBPROVI DER	0			41
00 04300 NURSERY	0	950, 666		42
00 04400 SKILLED NURSING FACILITY	0	0		44
00 04500 NURSING FACILITY	0	0		45
00 04600 OTHER LONG TERM CARE	0	0		46
ANCI LLARY SERVICE COST CENTERS	171 105	10 110 051	I	
00 05000 OPERATING ROOM 00 05100 RECOVERY ROOM	-171, 495	10, 418, 354		50 51
00 05200 DELIVERY ROOM & LABOR ROOM	-2, 850	-		52
00 05300 ANESTHESI OLOGY	0	0		53
00 05400 RADI OLOGY-DI AGNOSTI C	-942, 463	12, 652, 906		54
00 05500 RADI OLOGY-THERAPEUTI C	0			55
00 05600 RADI OI SOTOPE	0	-		56
00 05700 CT SCAN 00 05800 MRI	-6, 448	1, 081, 107 591, 467		57 58
00 05900 CARDI AC CATHETERI ZATI ON	-125, 681			59
00 06000 LABORATORY	-34, 915			60
01 06001 BLOOD LABORATORY	0	0		60
00 06100 PBP CLINICAL LAB SERVICES-PRGM	0	0		61
00 06200 WHOLE BLOOD & PACKED RED BLOOD 00 06300 BLOOD STORING PROCESSING & TRA	0	0		62
00 06400 INTRAVENOUS THERAPY	-31,008	599, 813		63 64
00 06500 RESPI RATORY THERAPY	-40			65
00 06600 PHYSI CAL THERAPY	-10, 559			66
00 06700 OCCUPATI ONAL THERAPY	0	0		67
00 06800 SPEECH PATHOLOGY	-5, 922			68
00 06900 ELECTROCARDI OLOGY	-20, 632			69
00 07000 ELECTROENCEPHALOGRAPHY 01 07001 SLEEP DI SORDER	0	79, 566 929, 808		70 70
00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	12, 242, 593		70
00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	16, 494, 391		72
00 07300 DRUGS CHARGED TO PATIENTS	0	23, 971, 214		73
00 07400 RENAL DI ALYSI S	0	0		74
00 07500 ASC (NON-DI STINCT PART)	0			75
00 03950 NUTRI TI ON/DI ABETES 97 07697 CARDI AC REHABI LI TATI ON	-28, 841	0 487, 169		76 76
OUTPATIENT SERVICE COST CENTERS	-20, 041	407,109	I	/0
00 08800 RURAL HEALTH CLINIC	0	0		88
00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			89
00 09000 CLINIC	-960			90
00 09100 EMERGENCY	-6, 480	5, 061, 715		91
00 09200 OBSERVATION BEDS (NON-DISTINCT				92
OTHER REIMBURSABLE COST CENTERS 00 09400 HOME PROGRAM DIALYSIS	0	0		94
00 09500 AMBULANCE SERVICES	0			94
00 09600 DURABLE MEDICAL EQUIP-RENTED	0			96
00 09700 DURABLE MEDICAL EQUIP-SOLD	0	l o		97

Health Financial Systems FLC	YD MEMORIAL HOSP	ITAL & HEALTH SVS	5	In Lieu	of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN	N: 150044	Peri od:	Worksheet A
				From 01/01/2015 To 12/31/2015	Date/Time Prepared:
				10 12/31/2015	5/27/2016 2:52 pm
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For			
		Allocation			
	6.00	7.00			
99.00 09900 CMHC	0	0			99.00
99. 10 09910 CORF	0	0			99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	17 017				100.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	-17, 817	3, 919, 834			101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0			105.00
106. 00 10600 HEART ACQUISTITION	0	0			105.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0			100.00
108. 00 10800 LUNG ACQUISTITION	0	0			108.00
109. 00 10900 PANCREAS ACQUISITION	0	0			109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0			110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	o			111.00
113.0011300 INTEREST EXPENSE	0	0			113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0			114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0			115.00
116. 00 11600 HOSPI CE	0	0			116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-18, 871, 666	221, 440, 857			118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0			190.00
191. 00 19100 RESEARCH	0	60, 203			191.00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	48, 761, 461			192.00
192.01 19201 OTHER NRCC	0	5, 561, 525			192.01
192.02 19202 LTC	0	29, 148, 604			192.02
193.00 19300 NONPALD WORKERS	0	0			193.00
194. 00 07950 MARKETI NG	0	1, 135, 697			194.00
200.00 TOTAL (SUM OF LINES 118-199)	-18, 871, 666	306, 108, 347			200.00

Health Financial Systems RECLASSIFICATIONS

FLOYD	MEMORI AL	HOSPI TAL	&	HEALTH	SVS		
			Р	rovi der	CCN:	150044	Period:

In Lieu of Form CMS-2552-10 Worksheet A-6

RECLAS	SI FI CATI ONS			Provi der	CCN: 150044	Period: From 01/01/2015	Worksheet A	-6
						To 12/31/2015		
		Increases					5/27/2016 2	<u>:52 pm</u>
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A – DRUGS							
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	23, 971, 214				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0_	0				4.00
	TOTALS		0	23, 971, 214				_
1 00	B - IMPLANTS	70.00		1/ 101 001	1			1.00
1.00	IMPL. DEV. CHARGED TO	72.00	0	16, 494, 391				1.00
	PATI ENTS	+	— —	16, 494, 391	-			
	C - SUPPLIES		0	10, 494, 391				_
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	28, 736, 984	1			1.00
1.00	PAT	71.00	0	20, 730, 704				1.00
2.00	ELECTROENCEPHALOGRAPHY	70.00	0	6				2.00
3.00		0,00	Ő	0				3.00
4.00		0.00	Ő	0				4.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00		0.00	O	0				8.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
14.00		0.00	0	0				14.00
15.00		0.00	0	0				15.00
16.00		0.00	0	0				16.00
17.00		0.00	0	0				17.00
18.00		0.00 0.00	0	0				18.00
19.00			0	28, 736, 990				19.00
	D - PROPERTY INSURANCE		U	20, 730, 990				_
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	262, 844				1.00
1.00	TOTALS		— — — <u> </u>	262, 844				1.00
	E - MASSAGE	I	<u> </u>	202,011				
1.00	PHYSI CAL THERAPY	66.00	26, 977	6, 684				1.00
	TOTALS		26, 977	6, 684				
	F - MARKETING							
1.00	ADMI NI STRATI VE & GENERAL	5.00	108, 793	362, 148				1.00
	TOTALS		108, 793	362, 148				
	G - NURSERY				-			
1.00	ADULTS & PEDIATRICS	30.00	958, 197	285, 867				1.00
2.00	NURSERY	43.00	732, 217	21 <u>8, 4</u> 49				2.00
	TOTALS		1, 690, 414	504, 316				
500.00	Grand Total: Increases		1, 826, 184	70, 338, 587	l			500.00

RECLAS	SI FI CATI ONS			Provi der	- CCN: 150044	Period: From 01/01/2015 To 12/31/2015		Prepared:
		Decreases				I	5/27/2016	2:52 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Rei	f.		
	6.00	7.00	8.00	9.00	10.00			
	A – DRUGS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 751		0		1.00
2.00	PHARMACY	15.00	0	12, 819, 844		0		2.00
3.00	CARDI AC CATHETERI ZATI ON	59.00	0	41, 729		0		3.00
4.00	INTRAVENOUS_THERAPY	64.00	0	<u>11, 106, 8</u> 90		Q		4.00
	TOTALS		0	23, 971, 214				
	B - IMPLANTS	1	i		1	- 1		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	16, 494, 391		0		1.00
	PAT	+				_		
	TOTALS		0	16, 494, 391				
	C - SUPPLIES	44.00		400 500	1			
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	182, 589		0		1.00
2.00	PHARMACY	15.00	0	133, 852		0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1, 167, 876		0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	224, 254		0		4.00
5.00	OPERATING ROOM	50.00	0	14, 254, 384		0		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	322, 234		0		6.00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 397, 334		0		7.00
8.00	CT_SCAN	57.00	0	167, 753		0		8.00
9.00		58.00	0	133, 477		0		9.00
10.00	CARDI AC CATHETERI ZATI ON	59.00	0	9, 538, 636		0		10.00
11.00 12.00	LABORATORY I NTRAVENOUS THERAPY	60.00	0	31,080		0		11.00
12.00	RESPIRATORY THERAPY	64.00 65.00	0	58, 498 216, 339		0		12.00
13.00	PHYSICAL THERAPY		0			0		13.00
	1	66.00	0	21, 032		0		
15.00	ELECTROCARDI OLOGY	69.00	0	9, 272		0		15.00
16.00	SLEEP DI SORDER	70.01	0	967		0		16.00
17.00 18.00	CARDI AC REHABI LI TATI ON CLI NI C	76. 97 90. 00	0	188		0		17.00
18.00	EMERGENCY	90.00 91.00	0	378, 843 498, 382		0		19.00
19.00	TOTALS		0	<u>496, 3</u> 82 28, 736, 990		<u>U</u>		19.00
	D - PROPERTY INSURANCE		U	20, 730, 990				
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	262, 844		12		1.00
1.00	TOTALS		0	262, 844		12		1.00
	E - MASSAGE		ų	202, 044				
1.00	ADMI NI STRATI VE & GENERAL	5.00	26, 977	6, 684		0		1.00
1.00	TOTALS		26, 977	6, 684				1.00
	F - MARKETING		20, 711	0,001				
1.00	MARKETING	194.00	108, 793	362, 148		0		1.00
	TOTALS		108, 793	362, 148				
	G - NURSERY			562, 110	<u>.</u>			
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 690, 414	504, 316		0		1.00
2.00		0.00	0	001,010		0		2.00
	TOTALS		1, 690, 414	504, 316		1		
	Grand Total: Decreases		1, 826, 184	70, 338, 587				500.00

FLOYD MEMORIAL HOSPITAL & HEALTH SVS In Lieu of Form CMS-2552-10

Health Financial Systems

Heal th I	Fi nanci a	I S	ystems		
RECONCI	LI ATI ON	0F	CAPI TAL	COSTS	CENTERS

In Lieu of Form CMS-2552-10 Worksheet A-7

					From To	01/01/2015 12/31/2015		oared: 2 pm
				Acquisition	IS			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	6, 258, 517	0		0	0	0	1.00
2.00	Land Improvements	3, 687, 772	63, 927		0	63, 927	0	2.00
3.00	Buildings and Fixtures	132, 235, 550	3, 547, 066		0	3, 547, 066	0	3.00
4.00	Building Improvements	4, 809, 555	0		0	0	281, 469	4.00
5.00	Fixed Equipment	16, 553, 939	1, 180, 918		0	1, 180, 918	0	5.00
6.00	Movable Equipment	136, 397, 420	4, 619, 503		0	4, 619, 503	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	299, 942, 753	9, 411, 414		0	9, 411, 414	281, 469	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	299, 942, 753	9, 411, 414		0	9, 411, 414	281, 469	10.00
		Endi ng	Ful I y					
		Bal ance	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	6, 258, 517	0					1.00
2.00	Land Improvements	3, 751, 699	0					2.00
3.00	Buildings and Fixtures	135, 782, 616	0					3.00
4.00	Building Improvements	4, 528, 086	0					4.00
5.00	Fixed Equipment	17, 734, 857	0					5.00
6.00	Movable Equipment	141, 016, 923	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	309, 072, 698	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	309, 072, 698	0					10.00

Heal th	Financial Systems FLOY	D MEMORIAL HOSP	ITAL & HEALTH	SVS	In Lie	u of Form CMS-2	2552-10
RECONC	LIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 To 12/31/2015		pared:
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLU	<u>WN 2, LINES 1 a</u>	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	3, 970, 327	0	4, 935, 69	0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9, 967, 145	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	13, 937, 472		4, 935, 69	0 0	0	3.00
		SUMMARY O	F CAPI TAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLUM	WN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	8, 906, 017				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9, 967, 145				2.00
3.00	Total (sum of lines 1-2)	0	18, 873, 162				3.00

Heal th	Financial Systems FLOYI	D MEMORIAL HOSP	PITAL & HEALTH	SVS	In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 To 12/31/2015		pared:
		COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
1.00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT	ENTERS 168, 055, 775	0	168, 055, 77	5 0. 543742	0	1.00
2.00	CAP REL COSTS-BEDG & FIXT	141, 016, 923		141, 016, 923			2.00
2.00	Total (sum of lines 1-2)	309, 072, 698		309, 072, 69			3.00
0.00		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
	Cost Center Description	Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0		3, 970, 327	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	, o	(9, 967, 145		2.00
3.00	Total (sum of lines 1-2)	0	0	(0 13, 937, 472	0	3.00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	I nsurance (see i nstructi ons)	Taxes (see instructions)	ed Costs (see		
		11.00	12.00	13.00	instructions) 14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	15.00	
1.00	CAP REL COSTS-BLDG & FIXT	4, 935, 690	262, 844		0 0	9, 168, 861	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0 0	9, 967, 145	2.00
3.00	Total (sum of lines 1-2)	4, 935, 690	262, 844		0 0	19, 136, 006	3.00
					1		•

In Lieu	u of Form CMS-2552-10
Peri od:	Worksheet A-8
From 01/01/2015	Dete /Time Decement

105051	MENTS TO EXPENSES			Provider CCN. 150044	From 01/01/2015 To 12/31/2015	Date/Time Pre 5/27/2016 2:53	pared:
			Tc	Expense Classification o /From Which the Amount is		572772010 2: 3	2 pm
		Dani a (Cada	Amount	Cost Costor		Wi+ A 7	
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne #	Wkst. A-7 <u>Ref.</u> 5.00	
. 00	Investment income - CAP REL	1.00		AP REL COSTS-BLDG & FIXT	1.00	0	1.00
. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		OCA	AP REL COSTS-MVBLE EQUIP	2.00	0	2.00
. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
. 00	(chapter 2) Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.0
. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.0
. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.0
. 00	Telephone services (pay stations excluded) (chapter 21)	A	-344, 736 AD	DMINISTRATIVE & GENERAL	5.00	0	7.0
. 00	Television and radio service (chapter 21)	A	-34, 513 AD	MINISTRATIVE & GENERAL	5.00	0	8.0
0. 00 0. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -2, 550, 520		0.00	0 0	9.00 10.00
1.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.0
2.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.0
3.00 4.00 5.00	Laundry and linen service Cafeteria-employees and guests Rental of quarters to employee and others		0 -1, 211, 458 DI 0	ETARY	0.00 10.00 0.00	0 0 0	14.0
5. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16.0
7.00	patients Sale of drugs to other than patients		0		0.00	0	17.0
8. 00	Sale of medical records and abstracts		0		0.00	0	18. C
9.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19. C
0. 00 1. 00	Vending machines Income from imposition of interest, finance or penalty		0 0		0. 00 0. 00	0 0	
2. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		О		0.00	0	22.0
3. 00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	ORE	ESPI RATORY THERAPY	65.00		23.0
4.00	Adjustment for physical therapy costs in excess of	A-8-3	OPH	IYSI CAL THERAPY	66.00		24. C
5. 00	limitation (chapter 14) Utilization review - physicians' compensation		τυο	TILIZATION REVIEW-SNF	114.00		25. C
5. 00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		OCA	AP REL COSTS-BLDG & FIXT	1.00	0	26.0
7.00			OCA	AP REL COSTS-MVBLE EQUIP	2.00	0	27.0
3. 00 9. 00	Non-physician Anesthetist Physicians' assistant		0 **	** Cost Center Deleted ***	* 19.00 0.00	0	28. 0 29. 0
	Adjustment for occupational therapy costs in excess of	A-8-3	oloc	CCUPATI ONAL THERAPY	67.00	0	30. C
). 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		OAD	OULTS & PEDIATRICS	30.00		30. 9
1. 00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	OSF	PEECH PATHOLOGY	68.00		31.0

In Lieu of Form CMS-2552-10 Worksheet A-8

ADJUS	IMENTS TO EXPENSES				Period: From 01/01/2015	Worksheet A-8	
					To 12/31/2015	Date/Time Pre 5/27/2016 2:5	
				Expense Classification on	Worksheet A	372772010 2.3	
			Т	o/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)	2.00	3.00	4.00	Ref. 5.00	
2.00	CAH HIT Adjustment for	1.00	2.00	3.00	4.00	0	32.0
2.00	Depreciation and Interest		0		0.00	0	02.0
3.00	RADIOLOGY - COPY FEES	В	-3, 350 R	ADI OLOGY-DI AGNOSTI C	54.00	9	33.0
3. 01	ADMIN - RENTAL INCOME	В		DMINISTRATIVE & GENERAL	5.00	0	33.0
3. 02	EMPLOYEE BENEFITS - MISC	В		MPLOYEE BENEFITS DEPARTMEN		0	
	REVENUE						
3.03	A & G - MISC REVENUE	В	-658, 829 A	DMINISTRATIVE & GENERAL	5.00	0	33.0
3. 04	PLANT OPERATIONS - MISC	В	-4, 1180	PERATION OF PLANT	7.00	0	33.0
	REVENUE						
3. 05	DIETARY - MISC REVENUE	В	-18, 401 D		10.00	0	
3.06		В		ENTRAL SERVICES & SUPPLY	14.00	0	
3.07	PHARMACY - MISC REVENUE	В	-597, 402 P		15.00	0	
3. 08	1	В		DULTS & PEDIATRICS	30.00	0	33.0
3.09	SURGERY - MI SC REVENUE	В		PERATING ROOM	50.00	0	
3. 10		В	-2, 850 D	DELIVERY ROOM & LABOR ROOM	52.00	0	33.1
	REVENUE	_				-	
33.11	RADI OLOGY - MI SC REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00	0	
33.12	MRI - MISC REVENUE	В	-6, 448 N		58.00	0	
33.13	CARDIAC CATH - MISC REVENUE	В		CARDI AC CATHETERI ZATI ON	59.00	0	
33.14	1	В		ABORATORY	60.00	0	33.1
33.15	IV THERAPY - MISC REVENUE	В		NTRAVENOUS THERAPY	64.00	0	
33. 16	RESPIRATORY THERAPY - MISC	В	-40R	RESPI RATORY THERAPY	65.00	0	33.1
33. 17	REVENUE PHYSI CAL THERAPY - MI SC	В	4 400	PHYSI CAL THERAPY	66.00	0	33.1
53.17	REVENUE	D	-0, 090 P	TISICAL THERAPT	00.00	0	33.1
33. 18	SPEECH THERAPY - MISC REVENUE	В	-5 9229	PEECH PATHOLOGY	68.00	0	33.1
33.19		В		LECTROCARDI OLOGY	69.00	0	
3. 20	CARDI AC REHAB - MI SC REVENUE	В		CARDI AC REHABI LI TATI ON	76.97	0	
33. 21	WOUND CARE - MI SC REVENUE	В		CLINIC	90.00	0	
33. 22	ER - MISC REVENUE	В		MERGENCY	91.00	0	
3.23	LOBBYING DUES	A		MMINISTRATIVE & GENERAL	5.00	0	
3. 24	EMPLOYEE BENEFITS -	A		MPLOYEE BENEFITS DEPARTMEN		11	
	ADVERTI SI NG						00.2
3. 25		А	-97, 262 A	DMINISTRATIVE & GENERAL	5.00	0	33.2
3. 26	PHYSICAL THERAPY - ADVERTISING	А		PHYSI CAL THERAPY	66.00	0	
3. 27	1	А		IOME HEALTH AGENCY	101.00	0	
3. 28	EMPLOYEE BENEFITS -	А		MPLOYEE BENEFITS DEPARTMEN		0	
	NONALLOWABLE EXP					-	
3. 29	ADMIN - NONALLOWABLE EXPENSES	А	-220, 738 A	DMINISTRATIVE & GENERAL	5.00	0	33.2
	RADI OLOGY - NONALLOWABLE	А		ADI OLOGY-DI AGNOSTI C	54.00	0	
	EXPENSES						
33.31	1	A		DMINISTRATIVE & GENERAL	5.00	0	
33.32	HAF FEE - CANCER CARE	A	-979, 233 R	ADI OLOGY-DI AGNOSTI C	54.00	0	33.3
	I NSTI TUTE						
50.00	TOTAL (sum of lines 1 thru 49)		-18, 871, 666				50.0
	(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 Syste	ems FLO'	/D MEMORIAL HOS	PITAL & HEALTH	SVS	In Lie	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provi der		Period: From 01/01/2015		
						To 12/31/2015	5 Date/Time Pre 5/27/2016 2:5	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	oz pili
	intot. A Erno "	I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	2, 616, 957	2, 510, 107	106, 850	179,000	772	1.00
2.00	0.00		0	0	C	0 0	0	2.00
3.00	0.00		0	0	C	0	0	3.00
4.00	0.00		0	0	C	0	0	4.00
5.00	0.00		0	0	C	0	0	5.00
6.00	0.00		0	0	C	0	0	6.00
7.00	0.00		0	0	C	0	0	7.00
8.00	0.00		0	0	C	0	0	8.00
9.00	0.00		0	0	C	0 0	0	9.00
10.00	0.00		0	0	C	0 0	0	10.00
200.00			2, 616, 957		106, 850		772	200.00
	Wkst. A Line #	2	Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Mal practi ce	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	0.00	0.00	0.00	Education	12	14.00	
1.00	1.00	2.00 ADULTS & PEDIATRICS	8.00	9.00	12.00	13.00	14.00	1.00
2.00	0.00	ADULIS & PEDIATRICS	00, 437		(2.00
2.00	0.00			0	(-	0	2.00
4.00	0.00		0				0	4.00
4.00 5.00	0.00		0				0	
6.00	0.00		0	0			0	6.00
7.00	0.00		0				0	7.00
8.00	0.00						0	8.00
9.00	0.00						0	9,00
10.00	0.00						-	10.00
200.00	0.00		66, 437	3, 322	(· ·		200.00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200.00
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	0	66, 437	40, 413			1.00
2.00	0.00		0	0	C	0		2.00
3.00	0.00		0	0	C	0		3.00
4.00	0.00		0	0	C	0		4.00
5.00	0.00		0	0	C	0		5.00
6.00	0.00		0	0	C	0 0		6.00
7.00	0.00		0	0	C	0		7.00
8.00	0.00		0	0	C	0 0		8.00
9.00	0.00		0	0	0	0 0		9.00
10.00	0.00		0	0)	0		10.00
200.00			0	66, 437	40, 413	2, 550, 520	1	200.00

	ALLOCATION - GENERAL SERVICE COSTS				From 01/01/2015 To 12/31/2015	Part I Date/Time Pre 5/27/2016 2:5	pared: 2 pm
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		(from Wkst A col. 7)					
		0	1.00	2.00	4.00	4A	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	9, 168, 861	9, 168, 861				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	9, 967, 145	, 100, 001	9, 967, 14	5		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 371, 033					4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	27, 654, 491	487, 454	3, 739, 06	5 445,911 0 0	32, 326, 921 0	5.00
7.00	00700 OPERATION OF PLANT	6, 910, 959	137, 727	2, 460, 69		9, 586, 098	6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 013, 424	130, 641		0 3, 789	1, 147, 854	8.00
9.00	00900 HOUSEKEEPI NG	2, 586, 705	33, 015			2, 690, 955	
10.00 11.00		2, 406, 197	50, 500 286, 472		3 77,671 0 0	2, 791, 061 286, 472	
12.00		0	0		0 0	0	
13.00		0	0		0 0	0	13.00
14.00		2,641,659	325, 395			3, 052, 209	
15.00 16.00		3, 685, 225 5, 398, 360	76, 249 146, 450			3, 921, 897 5, 719, 613	15.00 16.00
17.00		0,070,000	0		0 0	0,717,010	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 31.00		25, 227, 028				30, 070, 320	30.00 31.00
31.00		3, 422, 210	263, 677 0		0 112, 794 0 0	3, 823, 041 0	
33.00		0	0		0 0	0	33.00
34.00		0	0		0 0	0	34.00
40.00 41.00		0	0			0	40.00 41.00
41.00		0	0		0 0	0	41.00
43.00		950, 666	65, 430	7,82	6 30, 774	1, 054, 696	43.00
44.00		0	0		0 0	0	44.00
45.00 46.00		0	0		0 0 0 0	0	
10.00	ANCI LLARY SERVICE COST CENTERS		0		<u> </u>	0	10.00
50.00		10, 418, 354	845, 583	434, 33	4 288, 834	11, 987, 105	
51.00 52.00		0 1, 590, 827	0 518, 093	33, 57	0 0 4 51,733	0 2, 194, 227	51.00 52.00
53.00		1, 370, 027	075	55, 57	0 0	2, 174, 227	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 652, 906	568, 633	544, 93	6 316, 130	14, 082, 605	
55.00		0	0		0 0	0	55.00
56.00 57.00		1, 081, 107	71, 718	159, 98	0 0 1 22,614	0 1, 335, 420	56.00 57.00
58.00		591, 467	32, 815			816, 085	•
59.00		2, 617, 038				3, 207, 666	1
60.00		10, 570, 060	350, 665			11, 159, 783	
60. 01 61. 00		0	0		0 0	0	60.01 61.00
62.00		0	0		0 0	0	62.00
63.00		0	0		0 0	0	
64.00 65.00		599, 813 2, 592, 296	0 47, 326	36, 38	0 18, 973 1 79, 838	618, 786 2, 755, 841	64.00 65.00
66.00		4, 479, 368	6, 487			4, 629, 986	•
67.00		0	0		0 0	0	67.00
68.00		269, 844	11, 477		0 8, 608	289, 929	•
69.00 70.00		3, 218, 916 79, 566	180, 622 142, 517			3, 538, 721 228, 029	
70.00		929, 808	77, 945			1, 055, 894	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	12, 242, 593	0		0 0	12, 242, 593	
72.00		16, 494, 391	0		0 0	16, 494, 391	•
73.00 74.00		23, 971, 214				23, 971, 214 0	73.00 74.00
75.00		0	0		0 0	0	
76.00	03950 NUTRI TI ON/DI ABETES	0	0		0 0	0	76.00
76.97		487, 169	71, 718	26, 50	6 15, 111	600, 504	76.97
88.00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	88.00
89.00		0	0		0 0	0	89.00
90.00	09000 CLI NI C	1, 168, 608	112, 397			1, 304, 784	90.00
91.00 92.00		5,061,715	577, 056	74, 97	7 161, 878	5, 875, 626 0	91.00 92.00
72.00	09200 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS					0	72.00
94.00		0	0		0 0	0	94.00

In Lieu of Form CMS-2552-10 d: Worksheet B

COST ALLOCATION - CLINERAL SERVICE COSTS		11 OVI del	F	rom 01/01/2015 o 12/31/2015		epared: 52 pm
		CAPI TAL RELATED COSTS				
Cost Center Description	Net Expenses for Cost Allocation	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	(from Wkst A col. 7)			DEFACTMENT		
	0	1.00	2.00	4.00	4A	
95.00 09500 AMBULANCE SERVICES	0	0	C	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0	0	1 /0.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
99. 00 09900 CMHC	0	0	0	0	0	
99. 10 09910 CORF	0	0	C	0	0	1 / / / / 0
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	C	0	0	
101.00 10100 HOME HEALTH AGENCY	3, 919, 834	0	17, 935	116, 954	4, 054, 723	101.00
SPECIAL PURPOSE COST CENTERS						105 00
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON	0	0		0		105.00 106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0		107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0		0		107.00
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110,00
111. 00 11100 SLET ACQUI SI TI ON	0	0		0		111.00
113. 00 11300 I NTEREST EXPENSE	Ŭ	0	Ŭ	U U	0	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115.00
116.00 11600 HOSPI CE	0	0		0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	221, 440, 857	8, 981, 452	9, 650, 401	3, 569, 168	218, 915, 049	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	C	0	0	190.00
191. 00 19100 RESEARCH	60, 203	0	1, 333	2,009	63, 545	191.00
192.00 19200 PHYSI CLANS PRI VATE OFFI CES	48, 761, 461	65, 091	306, 324		50, 651, 513	
192.01 19201 OTHER NRCC	5, 561, 525	91, 818			5, 676, 950	
192. 02 19202 LTC	29, 148, 604	0	3, 687	476, 898	29, 629, 189	
193.00 19300 NONPALD WORKERS	0	0	C	0		193.00
194.0007950 MARKETI NG	1, 135, 697	30, 500	1, 145	4, 759	1, 172, 101	
200.00 Cross Foot Adjustments		-	_	_		200.00
201.00 Negative Cost Centers	00/ 100 0/7	0		0		201.00
202.00 TOTAL (sum lines 118-201)	306, 108, 347	9, 168, 861	9, 967, 145	5, 590, 823	306, 108, 347	202.00

Health Financial Systems FLOY COST ALLOCATION - GENERAL SERVICE COSTS			Provi der	1	Period: From 01/01/2015 Fo 12/31/2015		
						5/27/2016 2:5	
	Cost Center Description	E & GENERAL	MAI NTENANCE & REPAI RS	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
00	00100 CAP REL COSTS-BLDG & FIXT						1.0
00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
00	00400 EMPLOYEE BENEFITS DEPARTMENT	00.00/.001					4.
00	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS	32, 326, 921					5.
00 00	00700 OPERATION OF PLANT	0 1, 131, 888	-		5		6. 7.
00	00800 LAUNDRY & LINEN SERVICE	135, 534					8.
00	00900 HOUSEKEEPI NG	317, 737					
. 00	01000 DI ETARY	329, 557		64, 890			
. 00	01100 CAFETERI A	33, 825	0	368, 10	3 0	108, 576	11.
. 00	01200 MAINTENANCE OF PERSONNEL	0	0		0 0	-	
	01300 NURSING ADMINISTRATION	0	0		0 0		
	01400 CENTRAL SERVICES & SUPPLY	360, 393		418, 110			
	01500 PHARMACY	463, 082					
. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	675, 349 0					
. 00	INPATIENT ROUTINE SERVICE COST CENTERS	0	<u> </u>	<u>/</u>		0	1 17.
. 00	03000 ADULTS & PEDIATRICS	3, 550, 583	0	3, 772, 94	633, 877	1, 112, 869	30.
. 00	03100 I NTENSI VE CARE UNI T	451, 409		1 1 1			
. 00	03200 CORONARY CARE UNI T	0			0 0		
. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	33
00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	(0 0	0	
. 00	04000 SUBPROVI DER – I PF	0	0		0 0	0	
. 00	04100 SUBPROVI DER – I RF	0	0		0 0	0	
. 00	04200 SUBPROVI DER	0	0		0 0	0	
00	04300 NURSERY	124, 534		84,07			
00	04400 SKILLED NURSING FACILITY	0					
00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0					
00	ANCI LLARY SERVICE COST CENTERS	0		/ <u> </u>		0	40
00	05000 OPERATI NG ROOM	1, 415, 389	0	1, 086, 53	3 154, 972	320, 484	50
. 00	05100 RECOVERY ROOM	0		1 1 1	0 0		
. 00	05200 DELIVERY ROOM & LABOR ROOM	259, 086	0	665, 72	4 37, 968	196, 362	52.
00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.
00	05400 RADI OLOGY-DI AGNOSTI C	1, 662, 818	0	730, 66	5 91, 009	215, 517	54.
00	05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	-	
00	05600 RADI OI SOTOPE	0	(-	
00	05700 CT SCAN	157, 681		92, 15			
00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	96, 360 378, 748		,			
00	06000 LABORATORY	1, 317, 703		450, 58			
01	06001 BLOOD LABORATORY	0					
	06100 PBP CLINICAL LAB SERVICES-PRGM						61
	06200 WHOLE BLOOD & PACKED RED BLOOD	0	0		0 0	0	
00	06300 BLOOD STORING PROCESSING & TRA	0	(C		0 0	0	63
00	06400 INTRAVENOUS THERAPY	73, 064	0		0 0	0	64
00	06500 RESPI RATORY THERAPY	325, 399		60, 81			
00	06600 PHYSI CAL THERAPY	546, 690		8, 33			
00	06700 OCCUPATIONAL THERAPY	0				0	
00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	34, 234 417, 838		14, 74 232, 09		4, 350 68, 457	
	07000 ELECTROCARDI OLOGY	26, 925		183, 12		54, 015	
	07001 SLEEP DI SORDER	124, 676		100, 150			
	07100 MEDICAL SUPPLIES CHARGED TO PAT	1, 445, 556				0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 947, 592			0 0	0	
00	07300 DRUGS CHARGED TO PATIENTS	2, 830, 425	0) (0 0	0	73
	07400 RENAL DIALYSIS	0	0) (0	0	
	07500 ASC (NON-DI STINCT PART)	0	0) (0	0	
	03950 NUTRI TI ON/DI ABETES	0				0	
97	07697 CARDI AC REHABI LI TATI ON	70, 905	(92, 15	+ 0	27, 182	76
00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0				0	88
	08800 FEDERALLY QUALIFIED HEALTH CENTER						
	09000 CLINIC	154,064				-	
	09100 EMERGENCY	693, 770		741, 48			
	09200 OBSERVATION BEDS (NON-DISTINCT				.,2,,07		92
	OTHER REIMBURSABLE COST CENTERS						1
00	09400 HOME PROGRAM DI ALYSI S	0	(0 0	0	94
	09500 AMBULANCE SERVI CES	0	0) (0	0	
	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	0	
~ ~	09700 DURABLE MEDICAL EQUIP-SOLD	0	() (0 0	0	97
	09900 CMHC				0 0	0	99

Health Financial Systems	FLOYD MEMORIAL HOSP	ITAL & HEALTH S	SVS	In Lieu	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150044 P	eriod:	Worksheet B	
				rom 01/01/2015	Part I	
			T	0 12/31/2015	Date/Time Pre	
Cost Costos Decesistics			OPERATION OF	LAUNDRY &	5/27/2016 2:5 HOUSEKEEPI NG	2 pm
Cost Center Description	ADMI NI STRATI V E & GENERAL	REPAIRS	PLANT	LAUNDRY &	HOUSEKEEPING	
	5.00	6.00	7.00	8.00	9.00	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0.00	7.00			100.00
101. 00 10100 HOME HEALTH AGENCY	478, 765	0	0	0		100.00
SPECIAL PURPOSE COST CENTERS	478,703	U	0	0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0	105.00
106. 00 10600 HEART ACQUISITION	0	0	0	0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0	0	0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	o	o	0	o		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600 HOSPI CE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	22, 031, 579	0	10, 477, 175	1, 441, 527	3, 028, 323	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190.00
191. 00 19100 RESEARCH	7, 503	0	0	0		191.00
192.00 19200 PHYSI CLANS PRI VATE OFFI CES	5, 980, 634	0	83, 639		24, 670	
192.01 19201 OTHER NRCC	670, 312	0	117, 982	92	34, 800	
192. 02 19202 LTC	3, 498, 496	0	0	0		192.02
193.00 19300 NONPALD WORKERS	0	0	0	0		193.00
194. 00 07950 MARKETI NG	138, 397	0	39, 190	0	11, 560	
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118-201)	32, 326, 921	0	10, 717, 986	1, 451, 255	3, 099, 353	202.00

	Financial Systems FLOYI	D MEMORIAL HOSPI		CCN: 150044 Pe	eriod: rom 01/01/2015	u of Form CMS-2 Worksheet B Part I Date/Time Pre 5/27/2016 2:5	pared:
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI O N	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00 \end{array}$	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	3, 253, 612 0 0 0 0 0 0 0	796, 976 0 21, 566 24, 143 50, 163 0	0 0 0 0 0 0 0	0 0 0 0 0	3, 975, 612 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0		0	0	17.00
$\begin{array}{c} 30.\ 00\\ 31.\ 00\\ 32.\ 00\\ 33.\ 00\\ 34.\ 00\\ 40.\ 00\\ 41.\ 00\\ 42.\ 00\\ 43.\ 00\\ 44.\ 00\\ 45.\ 00\\ 46.\ 00\\ \end{array}$	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	2, 909, 843 139, 519 0 0 0 0 0 87, 659 0 0 0 0	252, 755 30, 892 0 0 0 0 0 8, 066 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00 31.00 32.00 33.00 34.00 40.00 41.00 42.00 43.00 44.00 45.00 46.00
50.00	ANCI LLARY SERVI CE COST CENTERS	4,200	79, 943	0	0	0	50.00
$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 55.\ 00\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 01\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 01\\ 71.\ 00\\ \end{array}$	05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05200 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM 06200 WHOLE BLOOD & PACKED RED BLOOD 06300 BLOOD STORI NG PROCESSI NG & TRA 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07001 SLEEP DI SORDER 07100 MEDI CAL SUPPLI ES CHARGED TO PAT	0 74, 194 0 1, 604 0 505 18 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 14, 246 0 43, 839 0 0 6, 678 3, 807 26, 635 52, 354 0 0 0 0 0 25, 620 16, 866 0 1, 721 19, 202 895 7, 624 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 01\\ 61.\ 00\\ 60.\ 01\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 70.\ 01\\ 71.\ 00\\ \end{array}$
74.00 75.00 76.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 03950 NUTRITION/DIABETES 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0 0 0 2,402			2, 281, 910 0 0 0 0 0	72.00 73.00 74.00 75.00 76.00 76.97 88.00
89.00 90.00 91.00 92.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	0 90 35, 439	0 5, 977 47, 384	0	0 0 0	000000000000000000000000000000000000000	80.00 89.00 90.00 91.00 92.00
94.00 95.00 96.00 97.00 99.00	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD 09900 CMHC	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0 0	94.00 95.00 96.00 97.00 99.00

Health Financial Systems FLOYE	MEMORIAL HOSP	ITAL & HEALTH	SVS	In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	Period: From 01/01/2015	Worksheet B Part I	
				Го 12/31/2015	Date/Time Pre 5/27/2016 2:5	
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
			OF PERSONNEL	ADMI NI STRATI O	SERVICES &	
	10.00	11.00	12.00	N 13.00	SUPPLY 14.00	
99. 10 09910 CORF	10.00	11.00	12.00	13.00	14.00	99, 10
100.0010000 I &R SERVICES-NOT APPRVD PRGM	0	0			-	100.00
101. 00 10100 HOME HEALTH AGENCY	0	27, 313				101.00
SPECIAL PURPOSE COST CENTERS	-1	,	-		-	
105.00 10500 KI DNEY ACQUI SI TI ON	0	0	(0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	0	0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	(0 0	0	107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0	(0 0	0	108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0	(0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	(0 0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	(0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	(0 0	0	115.00
116. 00 11600 HOSPI CE	0	0	(0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	3, 253, 612	770, 091	(0 0	3, 975, 612	118.00
NONREI MBURSABLE COST CENTERS	,					
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0		0 0		190.00
191. 00 19100 RESEARCH	0	610		0 0		191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	23, 169		0 0		192.00
192.01 19201 OTHER NRCC	0	1, 783	(0 0		192.01
192. 02 19202 LTC	0	0	(0 0		192.02
193. 00 19300 NONPAI D WORKERS	0	0	(0 0		193.00
194.00 07950 MARKETI NG	0	1, 323	(0 0	0	194.00
200.00 Cross Foot Adjustments		-			-	200.00
201.00 Negative Cost Centers	0	0				201.00
202.00 TOTAL (sum lines 118-201)	3, 253, 612	796, 976	I C	0 0	3, 975, 612	202.00

	Financial Systems FLO	<u>YD MEMORIAL HOSPI</u>		CCN: 150044	Peri od: From 01/01/2015 To 12/31/2015	u of Form CMS-: Worksheet B Part I Date/Time Pre 5/27/2016 2:5	pared:
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	17.00	24.00	25.00	
1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 LSTADY						1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00
13. 00 14. 00 15. 00	01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE INPATI ENT ROUTI NE SERVI CE COST CENTERS	4, 536, 587 0 0	6, 688, 812 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	5, 960, 712		0 48, 263, 906 0 4, 945, 961	0	1
32.00	03200 CORONARY CARE UNI T	0	0 0		0 4, 945, 961 0 0	0	32.00
33.00 34.00	03300 BURN I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0	0	33.00
40.00	04000 SUBPROVI DER – I PF	0	0		0 0	0	40.00
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0		0 0 0 0	0	
43.00	04300 NURSERY	0	0		0 1, 402, 082	0	43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		0 0	0	44.00
46.00	04600 OTHER LONG TERM CARE	0	0		0 0	0	
50.00	ANCI LLARY SERVI CE COST CENTERS	0	436, 860		0 15, 485, 486	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0		0 3, 441, 807 0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	24, 270		0 16, 852, 327	0	54.00
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0		0 0	0	55.00 56.00
57.00	05700 CT SCAN	0	0		0 1, 636, 449	0	57.00
		0	0		0 988, 018	0	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0		0 4, 059, 965 0 13, 113, 378	0	
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0	60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM 06200 WHOLE BLOOD & PACKED RED BLOOD	0	0		0 0	0	61.00 62.00
63.00	06300 BLOOD STORING PROCESSING & TRA	0	Ö		0 0	0	63.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 33, 978		0 691,850 0 3,219,587	0	64.00 65.00
	06600 PHYSI CAL THERAPY	0	24, 270		0 5, 271, 370	0	66.00
	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0 24, 270		0 344, 982 0 4, 300, 578	0	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 492, 992	0	
	07001 SLEEP DI SORDER 07100 MEDI CAL SUPPLI ES CHARGED TO PAT	0	0		0 1, 335, 405 0 15, 381, 851	0	70.01
	07200 I MPL. DEV. CHARGED TO PATI ENTS	0	0		0 20, 723, 893	0	1
	07300 DRUGS CHARGED TO PATIENTS	4, 536, 587	0		0 31, 338, 226	0	
	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0		0 0	0	
76.00	03950 NUTRI TI ON/DI ABETES	0	Ō		0 0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	0		0 793, 147	0	76.97
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	
	09000 CLINIC 09100 EMERGENCY	0	0 184, 452		0 1, 657, 553 0 7, 969, 639	0 0	
	09200 OBSERVATION BEDS (NON-DISTINCT	0				0	1
0/ 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S		0			0	94.00
	09500 AMBULANCE SERVICES	0	0		0 0	0	
0/ 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0			0	96.00

Health Financial Systems FLO	YD MEMORIAL HOSP	ITAL & HEALTH	SVS	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			CCN: 150044	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part I	pared:
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	15.00	16.00	17.00	24.00	25.00	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	
99.00 09900 CMHC	0	0		0 0	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
99. 10 09910 CORF	0	0		0 0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 4, 560, 801	0	101.00
SPECIAL PURPOSE COST CENTERS			_			
105.00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
116.00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	4, 536, 587	6, 688, 812		0 208, 271, 253	0	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 71,658	0	191.00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0		0 56, 773, 261	0	192.00
192.01 19201 OTHER NRCC	0	0		0 6, 501, 919	0	192.01
192. 02 19202 LTC	0	0		0 33, 127, 685	0	192.02
193.00 19300 NONPALD WORKERS	0	0		0 0		193.00
194. 00 07950 MARKETI NG	0	0		0 1, 362, 571	0	194.00
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	4, 536, 587	6, 688, 812		0 306, 108, 347		202.00

In Lieu of Form CMS-2552-10 Worksheet B

	ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150044 Period:	Worksheet B
			From 01 To 12	/01/2015 Part I 2/31/2015 Date/Time Prepared:
	Cost Center Description	Total	,,	5/27/2016 2:52 pm
	GENERAL SERVICE COST CENTERS	26.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00 6.00	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS			5.00
7.00	00700 OPERATI ON OF PLANT			7.00
8.00	00800 LAUNDRY & LINEN SERVICE			8.00
9.00	00900 HOUSEKEEPI NG			9.00
10.00	01000 DI ETARY 01100 CAFETERI A			10.00
	01200 MAINTENANCE OF PERSONNEL			12.00
	01300 NURSING ADMINISTRATION			13.00
	01400 CENTRAL SERVICES & SUPPLY			14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY			15.00 16.00
	01700 SOCIAL SERVICE			17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1 1		
	03000 ADULTS & PEDIATRICS	48, 263, 906		30.00
	03100 I NTENSI VE CARE UNI T	4, 945, 961		31.00
	03200 CORONARY CARE UNI T 03300 BURN I NTENSI VE CARE UNI T	0		32.00
	03400 SURGI CAL I NTENSI VE CARE UNI T	0		34.00
	04000 SUBPROVI DER – I PF	0		40.00
	04100 SUBPROVIDER - IRF	0		41.00
	04200 SUBPROVI DER 04300 NURSERY	0 1, 402, 082		42.00
	04400 SKILLED NURSING FACILITY	1, 402, 082		43.00
45.00		0		45.00
46.00		0		46.00
	ANCI LLARY SERVI CE COST CENTERS	15 405 404		E0.00
	05100 RECOVERY ROOM	15, 485, 486 0		50.00 51.00
	05200 DELIVERY ROOM & LABOR ROOM	3, 441, 807		52.00
53.00	05300 ANESTHESI OLOGY	0		53.00
	05400 RADI OLOGY-DI AGNOSTI C	16, 852, 327		54.00
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0		55.00 56.00
	05700 CT SCAN	1, 636, 449		57.00
	05800 MRI	988, 018		58.00
	05900 CARDI AC CATHETERI ZATI ON	4, 059, 965		59.00
	06000 LABORATORY 06001 BLOOD LABORATORY	13, 113, 378		60.00 60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM	0		61.00
62.00		0		62.00
	06300 BLOOD STORING PROCESSING & TRA	0		63.00
	06400 I NTRAVENOUS THERAPY	691,850		64.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 219, 587 5, 271, 370		65.00 66.00
	06700 OCCUPATI ONAL THERAPY	0		67.00
	06800 SPEECH PATHOLOGY	344, 982		68.00
	06900 ELECTROCARDI OLOGY	4, 300, 578		69.00
	07000 ELECTROENCEPHALOGRAPHY 07001 SLEEP DI SORDER	492, 992 1, 335, 405		70.00 70.01
	07100 MEDICAL SUPPLIES CHARGED TO PAT	15, 381, 851		70.01
	07200 I MPL. DEV. CHARGED TO PATIENTS	20, 723, 893		72.00
	07300 DRUGS CHARGED TO PATIENTS	31, 338, 226		73.00
	07400 RENAL DI ALYSI S	0		74.00
	07500 ASC (NON-DI STI NCT PART) 03950 NUTRI TI ON/DI ABETES	0		75.00 76.00
	07697 CARDI AC REHABI LI TATI ON	793, 147		76.97
	OUTPATIENT SERVICE COST CENTERS			
	08800 RURAL HEALTH CLINIC	0		88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0		89.00 90.00
	09000 CLINIC 09100 EMERGENCY	1, 657, 553 7, 969, 639		90.00
	09200 OBSERVATION BEDS (NON-DISTINCT	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		92.00
	OTHER REIMBURSABLE COST CENTERS	· ·		
	09400 HOME PROGRAM DI ALYSI S	0		94.00
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0		95.00 96.00
	09700 DURABLE MEDICAL EQUIP-RENTED	0		98.00
99.00	09900 CMHC	Ō		99.00
	09910 CORF	0		99.10
	10000 I&R SERVICES-NOT APPRVD PRGM	0		100.00

Health Financial Systems	FLOYD MEMORIAL HOSPITAL	& HEALTH SVS	In Lieu of Form CMS	S-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150044	Period: Worksheet B	
			From 01/01/2015 Part I To 12/31/2015 Date/Time P	roparad
			5/27/2016 2	
Cost Center Description	Total			
	26.00			
101.00 10100 HOME HEALTH AGENCY	4, 560, 801			101.00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KI DNEY ACQUI SI TI ON	0			105.00
106.00 10600 HEART ACQUI SI TI ON	0			106.00
107.00 10700 LIVER ACQUISITION	0			107.00
108.00 10800 LUNG ACQUI SI TI ON	0			108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0			109.00
110.00 11000 INTESTINAL ACQUISITION	0			110.00
111.00 11100 ISLET ACQUISITION	0			111.00
113.00 11300 INTEREST EXPENSE				113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0			115.00
116. 00 11600 HOSPI CE	0			116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	208, 271, 253			118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0			190.00
191. 00 19100 RESEARCH	71, 658			191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFICES	56, 773, 261			192.00
192. 01 19201 OTHER NRCC	6, 501, 919			192.01
192. 02 19202 LTC	33, 127, 685			192.02
193. 00 19300 NONPALD WORKERS				193.00
194. 00 07950 MARKETI NG	1, 362, 571			194.00
200.00 Cross Foot Adjustments	0			200.00
201.00 Negative Cost Centers	0			201.00
202.00 TOTAL (sum lines 118-201)	306, 108, 347			202.00

	I Financial Systems FLO ATION OF CAPITAL RELATED COSTS	YD MEMORIAL HOSP		CCN: 150044 P F	eriod: rom 01/01/2015 o 12/31/2015		epared:
			CAPI TAL REI	LATED COSTS		5/27/2016 2:5	
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
1 00	GENERAL SERVICE COST CENTERS			I			1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	202, 518	17, 272	219, 790	219, 790	1
5.00	00500 ADMI NI STRATI VE & GENERAL	0	487, 454			17, 527	1
6.00	00600 MAI NTENANCE & REPAI RS	0	0	-	0	0	6.00
7.00	00700 OPERATION OF PLANT	0	137, 727	2, 460, 699		3, 015	
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	130, 641 33, 015	5, 987	130, 641 39, 002	149	
9.00 10.00	01000 DI ETARY	0	50, 500			2, 565 3, 053	
11.00	01100 CAFETERI A	0	286, 472			0,000	
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	-	0	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	325, 395			1,766	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	76, 249 146, 450			5, 232 6, 517	
17.00	01700 SOCI AL SERVI CE	0	0			0, 517	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	2, 936, 257			32, 309	
	03100 INTENSIVE CARE UNIT	0	263, 677			4, 434	
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0	0	
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	1
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
42.00	04200 SUBPROVI DER	0	0	-		0	
43.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	65, 430 0			1, 210	
44.00 45.00	04500 NURSING FACILITY	0	0	-		0	
46.00	04600 OTHER LONG TERM CARE	0	0	-		0	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	845, 583	-		11, 353	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0 518, 093	0 33, 574	0 551, 667	0 2, 033	
53.00	05300 ANESTHESI OLOGY	0	0	0	0	2,039	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	568, 633	544, 936	1, 113, 569	12, 426	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	-	0	0	
56.00	05600 RADI OI SOTOPE	0	0	-	0	0	
57.00	05700 CT SCAN 05800 MRI	0	71, 718 32, 815				57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	224, 615			3,909	
60.00	06000 LABORATORY	0	350, 665			5, 827	1
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM				0	0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD 06300 BLOOD STORI NG PROCESSI NG & TRA	0			0	0	1
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	746	
65.00	06500 RESPIRATORY THERAPY	0	47, 326	-	83, 707	3, 138	1
66.00	06600 PHYSI CAL THERAPY	0	6, 487	28, 432	34, 919	4, 548	
	06700 OCCUPATI ONAL THERAPY	0	0	0		0	
68.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	11, 477 180, 622	0 57, 936		338 3, 194	1
	07000 ELECTROEARDI OLOGI	0	142, 517			100	
	07001 SLEEP DI SORDER	0	77, 945			1, 138	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
74.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0			0	0	
76.00	03950 NUTRI TI ON/DI ABETES	0	0	0	0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	0	71, 718	26, 506	98, 224	594	
00.00						-	
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	-	0	0	
90.00	09000 CLINIC	0	112, 397	, s	-	736	
91.00	09100 EMERGENCY	0	577, 056			6, 363	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT				0		92.00
01 00	OTHER REIMBURSABLE COST CENTERS					0	04 00
94.00 95.00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0				94.00 95.00
			. 0		. 0	0	1

ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150044 F	Peri od:	Worksheet B	
				From 01/01/2015	Part II	
			[]	Го 12/31/2015		epared:
			LATED COSTS		5/27/2016 2:5	p2 pm
		CAPITAL REL	LATED CUSTS			
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
oust center bescription	Assigned New	DEDG & TIXI		Subtotal	BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs				DELARTMENT	
	0	1.00	2.00	2A	4.00	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0			0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0 0	0	97.00
29. 00 09900 CMHC	0	0	0	0 0	0	99.00
99. 10 09910 CORF	0	0	0	0 0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	(0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	17, 935	5 17, 935	4, 597	101.00
SPECIAL PURPOSE COST CENTERS						1
105.00 10500 KIDNEY ACQUISITION	0	0	(0 0	0	105.00
106.00 10600 HEART ACQUISITION	0	0	0	0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0 0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0 0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0 0	0	115.00
116. 00 11600 HOSPI CE	0	0	0	0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	8, 981, 452	9, 650, 401	1 18, 631, 853	140, 291	118.00
NONREI MBURSABLE COST CENTERS			1			
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	(190.00
191. 00 19100 RESEARCH	0	0	1, 333			191.00
192.00 19200 PHYSI CLANS PRI VATE OFFI CES	0	65, 091			59, 727	
192. 01 19201 OTHER NRCC	0	91, 818				192. O
192. 02 19202 LTC	0	0			18, 745	
193.00 19300 NONPALD WORKERS	0	0	(193.00
194. 00 07950 MARKETI NG	0	30, 500	1, 145		187	194.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	-		201.00
202.00 TOTAL (sum lines 118-201)	0	9, 168, 861	9, 967, 145	5 19, 136, 006	219, 790	202.00

	TION OF CAPITAL RELATED COSTS	DYD MEMORIAL HOSE		CCN: 150044 P F T	In Lie eriod: rom 01/01/2015 o 12/31/2015 LAUNDRY &	u of Form CMS- Worksheet B Part II Date/Time Pre 5/27/2016 2:5 HOUSEKEEPING	pared:
	Cost Center Description	E & GENERAL 5. 00	REPAIRS 6.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	4, 244, 046					4.00 5.00
6.00	00600 MAINTENANCE & REPAIRS	4, 244, 040					6.00
7.00	00700 OPERATION OF PLANT	148, 604	-	2, 750, 045			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	17, 794	0	43, 072	191, 656		8.00
9.00	00900 HOUSEKEEPI NG	41, 715		10, 885	6, 371	100, 538	9.00
10.00	01000 DI ETARY	43, 267		16, 650	6, 466	621	10.00
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	4, 441		94, 449	0	3, 522 0	11.00
	01300 NURSI NG ADMI NI STRATI ON		-		0	0	12.00
	01400 CENTRAL SERVICES & SUPPLY	47, 315		107, 281	0	4,001	14.00
	01500 PHARMACY	60, 797		25, 139	78	937	15.00
	01600 MEDICAL RECORDS & LIBRARY	88, 665		48, 284	0	1, 801	16.00
17.00	01700 SOCI AL SERVI CE	C	0	0	0	0	17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	466, 150	0	968, 071	83, 712	36, 098	30.00
	03100 I NTENSI VE CARE UNI T	59, 265		86, 933		3, 242	31.00
	03200 CORONARY CARE UNIT	07,200		00,700	0,201	0,212	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	C	0	0	0	0	33.00
	03400 SURGI CAL I NTENSI VE CARE UNI T	C	0	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	C	0	0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	16, 350	0	0 21, 572	0 2, 411	0 804	42.00 43.00
43.00	04400 SKILLED NURSING FACILITY	10, 350		21, 372	2,411	0	43.00
45.00	04500 NURSING FACILITY			0	0	0	45.00
46.00	04600 OTHER LONG TERM CARE	C	0	0	0	0	46.00
	ANCI LLARY SERVI CE COST CENTERS		1				
	05000 OPERATING ROOM	185, 824				10, 396	50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	34, 015	-	0 170, 813	0 5, 014	0 6, 370	51.00 52.00
53.00	05300 ANESTHESI OLOGY	54,015		170, 813	5,014	0,370	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	218, 309	-	187, 476	12,019	6, 991	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	C	0	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	C	0	0	0	0	56.00
57.00	05700 CT SCAN	20, 702		23, 645		882	57.00
58.00 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	12, 651 49, 725		10, 819 74, 054	2, 264 9, 663	403 2, 762	58.00 59.00
60.00	06000 LABORATORY	172, 999		115, 613	9,003	4, 311	60.00
	06001 BLOOD LABORATORY	0		0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM						61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD	C	0	0	0	0	
63.00	06300 BLOOD STORING PROCESSING & TRA	0 502	0	0	0	0	63.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	9, 592 42, 721		0 15, 603	0	0 582	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	71, 774		2, 139		80	66.00
67.00	06700 OCCUPATI ONAL THERAPY	C	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	4, 494	0	3, 784	0	141	68.00
69.00	06900 ELECTROCARDI OLOGY	54, 857		59, 550	0	2, 221	69.00
		3, 535		46, 987	0	1, 752	70.00
	07001 SLEEP DI SORDER 07100 MEDI CAL SUPPLI ES CHARGED TO PAT	16, 368 189, 785		25, 698	2, 241	958 0	70.01
	07200 IMPL. DEV. CHARGED TO PATIENTS	255, 696			0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	371, 602		0	0	0	73.00
74.00	07400 RENAL DIALYSIS	C	0	0	0	0	74.00
	07500 ASC (NON-DISTINCT PART)	C	0	0	0	0	75.00
	03950 NUTRI TI ON/DI ABETES	C	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	9, 309	0	23, 645	0	882	76.97
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		-	0	0	0	89.00
90.00	09000 CLINIC	20, 227	0	37, 057	741	1, 382	90.00
	09100 EMERGENCY	91, 084	0	190, 253	22, 816	7, 095	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT			l			92.00
94.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	94.00
	09500 AMBULANCE SERVICES		0	n 0	0	0	94.00
	09600 DURABLE MEDI CAL EQUI P-RENTED	0	o o	0	0	0	96.00
	09700 DURABLE MEDICAL EQUIP-SOLD	C	0	0	0	0	97.00
	09900 CMHC	0	0	0	0	0	99.00
99.10	09910 CORF	C	<u>0</u>	0	0	0	99.10

Health Financial Systems FLO	D MEMORIAL HOSP	ITAL & HEALTH	svs	In Lieu	」of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS			CCN: 150044 P	eriod: rom 01/01/2015	Worksheet B Part II
			Т		Date/Time Prepared: 5/27/2016 2:52 pm
Cost Center Description	ADMI NI STRATI V		OPERATI ON OF	LAUNDRY &	HOUSEKEEPING
	E & GENERAL	REPAI RS	PLANT	LINEN SERVICE	
	5.00	6.00	7.00	8.00	9.00
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100. 00
101.00 10100 HOME HEALTH AGENCY	62, 856	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS	1				
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0 105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	0	0	0 106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0	0	0	0 107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0	0	0	0 109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0 111.00
113.00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTILIZATION REVIEW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0 115.00
116.00 11600 HOSPI CE	0	0	0	0	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2, 892, 488	0	2, 688, 257	190, 371	98, 234 118. 00
NONREI MBURSABLE COST CENTERS		-	-	-1	
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0 190. 00
191.00 19100 RESEARCH	985	0	0	0	0 191.00
192.00 19200 PHYSI CLANS PRI VATE OFFI CES	785, 087	0	21, 460	· · ·	800 192.00
192.01 19201 OTHER NRCC	88,004	0	30, 272	12	1, 129 192. 01
192.02 19202 LTC	459, 312	0	0	0	0 192.02
193.00 19300 NONPALD WORKERS	0	0	0	0	0 193.00
194. 00 07950 MARKETI NG	18, 170	0	10, 056	0	375 194.00
200.00 Cross Foot Adjustments			-		200.00
201.00 Negative Cost Centers	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118-201)	4, 244, 046	0	2, 750, 045	191, 656	100, 538 202. 00

	Financial Systems FLOY TION OF CAPITAL RELATED COSTS	D MEMORIAL HOSPI		CCN: 150044 P	eriod: rom 01/01/2015	u of Form CMS-2 Worksheet B Part II Date/Time Pre 5/27/2016 2:5	pared:
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI O N	CENTRAL SERVICES & SUPPLY	2 pm
		10.00	11.00	12.00	13.00	14.00	
15. 00 16. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	377, 250 0 0 0 0 0 0 0 0 0 0 0	388, 884 0 10, 523 11, 781 24, 477 0	0 0 0 0	0 0 0 0 0 0	536, 494 0 0 0	15.00 16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	227 200	400.004				
$\begin{array}{c} 30.\ 00\\ 31.\ 00\\ 32.\ 00\\ 33.\ 00\\ 34.\ 00\\ 40.\ 00\\ 41.\ 00\\ 42.\ 00\\ 43.\ 00\\ 44.\ 00\\ 45.\ 00\\ 46.\ 00\\ \end{array}$	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	337, 390 16, 177 0 0 0 0 0 0 0 0 10, 164 0 0 0 0	123, 331 15, 074 0 0 0 0 0 0 3, 936 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00 32.00 33.00 34.00 40.00 41.00 42.00 43.00 44.00 45.00
50.00	05000 OPERATING ROOM	487	39,008	0	0	0	50.00
$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 01\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 70.\ 01\\ 71.\ 00\\ 70.\ 01\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 75.\ 00\\ 76.\ 97\\ 88.\ 00\\ \end{array}$	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM 06200 WHOLE BLOOD & PACKED RED BLOOD 06300 BLOOD STORI NG PROCESSI NG & TRA 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06600 PHYSI CAL THERAPY 06600 SEECH PATHOLOGY 06600 PHYSI CAL SUPPLI ES CHARGED TO PAT 07001 SLEEP DI SORDER 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 07200 I IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 03950 NUTRI TI ON/DI ABETES 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C	487 0 8,603 0 186 0 0 59 2 0 <	39,008 0 6,951 0 21,391 0 0 3,259 1,858 12,996 25,546 25,546 0 0 0 12,501 8,230 0 12,501 8,230 0 0 840 9,370 437 3,720 0 0 0 0 0 0 1,172			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 55.\ 00\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 01\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 67.\ 00\\ 70.\ 01\\ 71.\ 00\\ 70.\ 01\\ 71.\ 00\\ 73.\ 00\\ 74.\ 00\\ 75.\ 00\\ 76.\ 97\\ 88.\ 00\\ \end{array}$
88.00 89.00 90.00 91.00 92.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT	0 0 10 4, 109	0 0 2, 917 23, 121	0	0 0 0	000000000000000000000000000000000000000	89.00 90.00
	OTHER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD 09900 CMHC		0 0 0 0 0	0 0 0 0 0	0 0 0 0 0	0 0 0 0 0 0	95.00 96.00 97.00

Health Financial Systems F	LOYD MEMORIAL HOSPI	TAL & HEALTH	SVS	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150044 F	Period:	Worksheet B
				rom 01/01/2015	
			T	To 12/31/2015	Date/Time Prepared:
	DIFTADY				5/27/2016 2:52 pm
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL
			OF PERSONNEL	ADMI NI STRATI O	SERVICES &
	10.00	11 00	10.00	N 12.00	SUPPLY 14 00
00.40.00040.0005	10.00	11.00	12.00	13.00	14.00
99.10 09910 CORF	0	0		0	0 99.10
100.00 10000 I & SERVICES-NOT APPRVD PRGM	0	0		0	0 100.00
101.00 HOME HEALTH AGENCY	0	13, 327	(0	0 101.00
SPECIAL PURPOSE COST CENTERS			-	- I	
105.00 10500 KI DNEY ACQUI SI TI ON	0	0	(0 0	0 105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	C	0 0	0 106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0 0	0 107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0	0	0 0	0 108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0	0	0 0	0 109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0 0	0 110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0 0	0 111.00
113.0011300INTEREST EXPENSE					113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	C	0 0	0 115.00
116.00 11600 HOSPI CE	0	0	0	0 0	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	377, 250	375, 766	C	0 0	536, 494 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	(0 0	0 190. 00
191. 00 19100 RESEARCH	0	298	0	0 0	0 191.00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	11, 305	0	0 0	0 192.00
192.01 19201 OTHER NRCC	0	870	0	0 0	0 192.01
192. 02 19202 LTC	0	0	0	0 0	0 192.02
193.00 19300 NONPALD WORKERS	0	0	(0 0	0 193.00
194. 00 07950 MARKETI NG	0	645	C	o o	0 194.00
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers	0	0	0	0 0	0 201.00
202.00 TOTAL (sum lines 118-201)	377, 250	388, 884	0	0 0	536, 494 202. 00

1.00 0 2.00 0 4.00 0 5.00 0 6.00 0 7.00 0 8.00 0 9.00 0 11.00 0 12.00 0 13.00 0 14.00 0 15.00 0	Cost Center Description GENERAL SERVICE COST CENTERS D0100 CAP REL COSTS-BLDG & FIXT D0200 CAP REL COSTS-MVBLE EQUIP D0400 EMPLOYEE BENEFITS DEPARTMENT D0500 ADMINISTRATIVE & GENERAL D0600 MAINTENANCE & REPAIRS D0700 OPERATION OF PLANT D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DI ETARY D1100 CAFETERIA D1200 MAINTENANCE OF PERSONNEL D1300 NURSING ADMINISTRATION	PHARMACY 15.00	MEDI CAL RECORDS & LI BRARY 16. 00	SOCI AL SERVI CE 17.00	Subtotal 24.00	5/27/2016 2:5 Intern & Residents Cost & Post Stepdown Adjustments 25.00	1.00 2.00 4.00 5.00 6.00
1.00 0 2.00 0 4.00 0 5.00 0 6.00 0 7.00 0 8.00 0 9.00 0 11.00 0 12.00 0 13.00 0 14.00 0 15.00 0	DO100 CAP REL COSTS-BLDG & FIXT DO200 CAP REL COSTS-MVBLE EQUIP DO400 EMPLOYEE BENEFITS DEPARTMENT DO500 ADMINISTRATIVE & GENERAL DO600 MAINTENANCE & REPAIRS D0700 OPERATION OF PLANT D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1200 MAINTENANCE OF PERSONNEL	15.00	16.00	17.00	24.00	25.00	2.00 4.00 5.00
1.00 0 2.00 0 4.00 0 5.00 0 6.00 0 7.00 0 8.00 0 9.00 0 11.00 0 12.00 0 13.00 0 14.00 0 15.00 0	DO100 CAP REL COSTS-BLDG & FIXT DO200 CAP REL COSTS-MVBLE EQUIP DO400 EMPLOYEE BENEFITS DEPARTMENT DO500 ADMINISTRATIVE & GENERAL DO600 MAINTENANCE & REPAIRS D0700 OPERATION OF PLANT D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1200 MAINTENANCE OF PERSONNEL						2.00 4.00 5.00
	01400 CENTRAL SERVICES & SUPPLY						7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
	D1500 PHARMACY D1600 MEDI CAL RECORDS & LI BRARY D1700 SOCI AL SERVI CE	207, 516 0 0	325, 194 0		0		15.00 16.00 17.00
	NPATIENT ROUTINE SERVICE COST CENTERS	-					
31.00 0 32.00 0 33.00 0 34.00 0 40.00 0 41.00 0 42.00 0	D3000 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT D3200 CORONARY CARE UNIT D3300 BURN INTENSIVE CARE UNIT D3400 SURGICAL INTENSIVE CARE UNIT D4000 SUBPROVIDER - IPF D4100 SUBPROVIDER - IRF D4200 SUBPROVIDER D4200 NURSERY		289, 795 0 0 0 0 0 0 0 0		0 6, 358, 154 0 481, 396 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 129, 703	0 0 0 0 0 0 0 0 0 0 0	31.00 32.00 33.00 34.00 40.00 41.00 42.00
	04400 SKILLED NURSING FACILITY	0	0		0 129,703	0	1
	04500 NURSI NG FACI LI TY	0	0		0 0	0	45.00
	04600 OTHER LONG TERM CARE	0	0		0 0	0	46.00
	ANCI LLARY SERVICE COST CENTERS	0	21 220		0 1, 847, 475	0	50.00
	D5100 RECOVERY ROOM	0	21, 239 0		0 1, 847, 475 0 0	0	
52.00	D5200 DELIVERY ROOM & LABOR ROOM	0	0		0 785, 466	0	52.00
	05300 ANESTHESI OLOGY	0	0		0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	1, 180 0		0 1, 573, 547	0	54.0 55.0
	D5600 RADI OI SOTOPE	0	0		0 0	0	56.0
	D5700 CT SCAN	0	0		0 283, 357	0	57.0
	05800 MRI	0	0		0 238, 319	0	
1	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0		0 644, 296	0	07.0
1	D6000 LABORATORY	0	0		0 765, 786 0 0	0	60.0
61.00	D6100 PBP CLINICAL LAB SERVICES-PRGM						61.0
	06200 WHOLE BLOOD & PACKED RED BLOOD	0	0		0 0	0	
	D6300 BLOOD STORI NG PROCESSI NG & TRA D6400 I NTRAVENOUS THERAPY	0	0		0 10, 338	0	63.0 64.0
1	06500 RESPI RATORY THERAPY	0	1, 652		0 159, 904	0	65.0
1	D6600 PHYSI CAL THERAPY	0	1, 180		0 128, 517	0	66.0
1	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0 0 0	0	67.0 68.0
	D6900 ELECTROCARDI OLOGY	0	1, 180		0 21,074 0 368,930	0	69.0
	D7000 ELECTROENCEPHALOGRAPHY	0	0		0 198, 719	0	
	07001 SLEEP DI SORDER	0	0		0 147, 317	0	70.0
	07100 MEDICAL SUPPLIES CHARGED TO PAT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 418, 342 0 563, 633	0	71.0
	D7300 DRUGS CHARGED TO PATIENTS	207, 516	0		0 579, 118	0	
74.00	07400 RENAL DIALYSIS	0	0		0 0	0	
	07500 ASC (NON-DI STI NCT PART)	0	0		0 0	0	
	03950 NUTRI TI ON/DI ABETES	0	0		0 0 0	0	
	D7697 CARDIAC REHABILITATION DUTPATIENT SERVICE COST CENTERS	0	U		0 133, 826	0	76.9
	D8800 RURAL HEALTH CLINIC	0	0		0 0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
		0	0		0 180, 527	0	
1	D9100 EMERGENCY D9200 OBSERVATION BEDS (NON-DISTINCT	0	8, 968		0 1, 005, 842	0	
-	OTHER REIMBURSABLE COST CENTERS					0	/2.0
	D9400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	
1	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	

Health Financial Systems	FLOYD MEMORIAL HOSP	TAL & HEALTH	SVS		Inlie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			CCN: 150044	Per	~i od:	Worksheet B	2002 10
					om 01/01/2015	Part II	
				To	12/31/2015		pared:
						5/27/2016 2:5	2 pm
Cost Center Description	PHARMACY	MEDI CAL	SOCI AL		Subtotal	Intern &	
		RECORDS &	SERVI CE			Resi dents	
		LI BRARY				Cost & Post	
						Stepdown	
						Adjustments	
	15.00	16.00	17.00		24.00	25.00	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	0	97.00
99.00 09900 CMHC	0	0		0	0	0	99.00
99. 10 09910 CORF	0	0		0	0	0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0	98, 715	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00 10500 KI DNEY ACQUI SI TI ON	0	0		0	0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0		0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0	0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0	0	0	111.00
113.00 11300 INTEREST EXPENSE							113.00
114.00 11400 UTILIZATION REVIEW-SNF							114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	o	0		0	o	0	115.00
116.00 11600 HOSPI CE	0	0		0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	207, 516	325, 194		0	17, 122, 301		118.00
NONREI MBURSABLE COST CENTERS			r				
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0		0	0	0	190.00
191, 00 19100 RESEARCH	0	0		0	2, 695	0	191.00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0		0	1, 251, 067	0	192.00
192. 01 19201 OTHER NRCC	0	0		0	217, 121		192.01
192. 02 19202 LTC	0	0		0	481, 744		192.02
193. 00 19300 NONPALD WORKERS	0	0		Ō	0		193.00
194. 00 07950 MARKETI NG	0	0		õ	61, 078		194.00
200.00 Cross Foot Adjustments		0		Ŭ	0.,0,0		200.00
201.00 Negative Cost Centers	0	٥		0	0		200.00
202.00 TOTAL (sum Lines 118-201)	207, 516	325, 194		0	19, 136, 006		202.00
	207,010	020,174	I	~	17, 100, 000	0	- 52.00

In Lieu of Form CMS-2552-10 Worksheet B

ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CCN: 150044	Period: Worksheet B	
				From 01/01/2015 Part II To 12/31/2015 Date/Time Pr	
	Cost Center Description	Total		5/27/2016 2:	52 pm
	cost center bescription	26.00			
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 6.00	00500 ADMINI STRATI VE & GENERAL				5.00 6.00
8.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
	01100 CAFETERI A				11.00
	01200 MAINTENANCE OF PERSONNEL				12.00
13.00	01300 NURSING ADMINISTRATION				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
	01500 PHARMACY				15.00
	01600 MEDICAL RECORDS & LIBRARY				16.00
17.00	01700 SOCIAL SERVICE				17.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	6, 358, 154			30.00
	03200 CORONARY CARE UNIT	481, 396			31.00 32.00
	03300 BURN INTENSIVE CARE UNIT	0			32.00
	03400 SURGI CAL I NTENSI VE CARE UNI T	0			34.00
	04000 SUBPROVI DER – I PF	0			40.00
	04100 SUBPROVIDER - IRF	0			41.00
	04200 SUBPROVI DER	0			42.00
	04300 NURSERY	129, 703			43.00
	04400 SKILLED NURSING FACILITY	0			44.00
45.00	04500 NURSING FACILITY	0			45.00
46.00	04600 OTHER LONG TERM CARE	0			46.00
	ANCILLARY SERVICE COST CENTERS	1			
50.00	05000 OPERATING ROOM	1, 847, 475			50.00
	05100 RECOVERY ROOM	0			51.00
	05200 DELIVERY ROOM & LABOR ROOM	785, 466			52.00
	05300 ANESTHESI OLOGY				53.00
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	1, 573, 547			54.00 55.00
56.00	05600 RADI OLOGI - THERAPEOTIC	0			56.00
57.00	05700 CT SCAN	283, 357			57.00
58.00	05800 MRI	238, 319			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	644, 296			59.00
60.00	06000 LABORATORY	765, 786			60.00
60.01	06001 BLOOD LABORATORY	0			60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM				61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	0			62.00
	06300 BLOOD STORING PROCESSING & TRA	0			63.00
	06400 I NTRAVENOUS THERAPY	10, 338			64.00
	06500 RESPI RATORY THERAPY	159, 904			65.00
	06600 PHYSI CAL THERAPY	128, 517			66.00
	06700 OCCUPATI ONAL THERAPY	0			67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	21,074			68.00
	07000 ELECTROCARDI OLOGY	368, 930 198, 719			69.00 70.00
	07001 SLEEP DI SORDER	198, 719			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PAT	418, 342			71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	563, 633			72.00
	07300 DRUGS CHARGED TO PATIENTS	579, 118			73.00
	07400 RENAL DI ALYSI S	0			74.00
75.00	07500 ASC (NON-DISTINCT PART)	0			75.00
	03950 NUTRI TI ON/DI ABETES	0			76.00
76.97	07697 CARDI AC REHABI LI TATI ON	133, 826			76.97
	OUTPATIENT SERVICE COST CENTERS				
	08800 RURAL HEALTH CLINIC	0			88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	100 527			89.00
		180, 527			90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT	1,005,842			91.00 92.00
72. UU	OTHER REIMBURSABLE COST CENTERS				72.00
94 00	09400 HOME PROGRAM DI ALYSI S	0			94.00
	09500 AMBULANCE SERVICES	0			95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0			96.00
	09700 DURABLE MEDICAL EQUIP-SOLD	Ő			97.00
	09900 CMHC	0			99.00
	09910 CORF	0			99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0			100.00
5/27/2	016 2:52 pm C:\MCRLE32\ELovd2015 mcrx				

Health Financial Systems	FLOYD MEMORIAL HOSPITAL	_ & HEALTH SVS	In Lieu	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150044	Peri od:	Worksheet B
			From 01/01/2015 To 12/31/2015	Part II Date/Time Prepared:
			10 12/31/2013	5/27/2016 2:52 pm
Cost Center Description	Total			
	26.00			
101.0010100 HOME HEALTH AGENCY	98, 715			101. 00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KIDNEY ACQUISITION	0			105.00
106. 00 10600 HEART ACQUI SI TI ON	0			106.00
107.00 10700 LI VER ACQUI SI TI ON	0			107.00
108.00 10800 LUNG ACQUI SI TI ON	0			108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0			109.00
110.00 11000 INTESTINAL ACQUISITION	0			110.00
111.00 11100 I SLET ACQUI SI TI ON	0			111.00
113.0011300 INTEREST EXPENSE				113.00
114.00 11400 UTILIZATION REVIEW-SNF				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0			115.00
116. 00 11600 HOSPI CE	0			116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	17, 122, 301			118.00
NONREI MBURSABLE COST CENTERS	F I			
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0			190.00
191. 00 19100 RESEARCH	2, 695			191.00
192.00 19200 PHYSI CLANS PRI VATE OFFI CES	1, 251, 067			192.00
192. 01 19201 OTHER NRCC	217, 121			192.01
192. 02 19202 LTC	481, 744			192.02
193.00 19300 NONPALD WORKERS	0			193.00
194. 00 07950 MARKETI NG	61, 078			194.00
200.00 Cross Foot Adjustments	0			200.00
201.00 Negative Cost Centers	0			201.00
202.00 TOTAL (sum lines 118-201)	19, 136, 006			202.00

In Lieu of Form CMS-2552-10 Worksheet B-1

COST A	ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2015		
		CAPI TAL REL	ATED COSTS		To 12/31/2015	Date/Time Pre 5/27/2016 2:5	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	
		1.00	2.00	SALARIES) 4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	54	3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	459, 352					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		14,001,971				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	10, 146	24, 264			070 704 404	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	24, 421	5, 252, 692			273, 781, 426	
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	6, 900	3, 456, 820		0 C 6 C		
8.00	00800 LAUNDRY & LI NEN SERVI CE	6, 545	0, 100, 020	90, 14		1, 147, 854	
9.00	00900 HOUSEKEEPI NG	1, 654	8, 411				
10.00	01000 DI ETARY	2, 530	360, 605	1, 848, 04	5 C	2, 791, 061	
11.00		14, 352	0		0 0		
12.00 13.00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0	0			0	
14.00	01400 CENTRAL SERVICES & SUPPLY	16, 302	56, 492	1, 069, 29		3, 052, 209	
15.00		3, 820	38, 356			3, 921, 897	
16.00	01600 MEDICAL RECORDS & LIBRARY	7, 337	12, 644				
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	147, 104	1, 524, 279	10 557 70	1 C	30, 070, 320	30.00
30.00		13, 210	34, 221				
32.00		0	01,221				1
33.00		0	0		0 0	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 C	0	
40.00	04000 SUBPROVI DER - I PF	0	0		0 0	0	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0			0	1
42.00	04300 NURSERY	3, 278	10, 994			1, 054, 696	
44.00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	
45.00	04500 NURSING FACILITY	0	0		0 C		1
46.00		0	0		0 0	0	46.00
50.00	ANCI LLARY SERVI CE COST CENTERS	42, 363	610, 158	6, 872, 25	6 C	11, 987, 105	50.00
51.00	05100 RECOVERY ROOM	0	0				1
52.00	05200 DELIVERY ROOM & LABOR ROOM	25, 956	47, 165	1, 230, 88	5 C	2, 194, 227	52.00
53.00		0	0		0 0	0	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	28, 488	765, 532		5 C	14, 082, 605 0	1
56.00	05600 RADI OLOGI - MERAPEOTI C	0	0			0	1
57.00	05700 CT SCAN	3, 593	224, 743	538, 05	6 C	1, 335, 420	1
58.00		1, 644	248, 542	354,06	7 C	816, 085	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	11, 253	374, 483				1
	06000 LABORATORY	17, 568	127, 583	1			
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM	0	0			0	60.01 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	0	0		0 0	0	1
63.00	06300 BLOOD STORING PROCESSING & TRA	0	0		0 0	0	1
64.00		0	0	451, 41		618, 786	1
65.00	06500 RESPI RATORY THERAPY	2, 371	51, 108			2, 755, 841	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	325	39, 941		6 C 0 C	4, 629, 986	1
67.00 68.00		575	0		-	0 289, 929	1
69.00		9,049	81, 389			3, 538, 721	
	07000 ELECTROENCEPHALOGRAPHY	7, 140	4, 764			228, 029	
70. 01		3, 905	26, 953			1, 055, 894	1
71.00		0	0		0 0		
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0			16, 494, 391 23, 971, 214	72.00 73.00
73.00		0	0			23, 971, 214	
		0	0		0 0	0	1
76.00	03950 NUTRI TI ON/DI ABETES	0	0		0 0	0	1
76.97	07697 CARDI AC REHABI LI TATI ON	3, 593	37, 236	359, 53	8 C	600, 504	76.97
00 00	OUTPATIENT SERVICE COST CENTERS	0	0	1	ol c	0	88.00
88.00 89.00		0	0			0	1
90.00		5, 631	7, 109		-	1, 304, 784	
91.00	09100 EMERGENCY	28, 910	105, 328			5, 875, 626	91.00
92.00							92.00
04 00	OTHER REIMBURSABLE COST CENTERS		0	1		0	04.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	1	0 C	0	94.00

	ared:
Cost Center Description CAPITAL RELATED COSTS EMPLOYEE Reconciliatio ADMINISTRATIV BLDG & FIXT (SQUARE FEET) MVBLE EQUIP (DOLLAR VALUE) EMPLOYEE Reconciliatio ADMINISTRATIV E & GENERAL (ACCUM. COST) 1.00 2.00 4.00 5A 5.00 95.00 09500 AMBULANCE SERVICES 0 0 0 0	nm
CAPI TAL RELATED COSTS EMPLOYEE Reconciliatio ADMINISTRATIV BLDG & FIXT (SQUARE FEET) MVBLE EQUIP (DOLLAR VALUE) EMPLOYEE Reconciliatio ADMINISTRATIV E & GENERAL (ACCUM. COST) 1.00 2.00 4.00 5A 5.00 95.00 09500 AMBULANCE SERVICES 0 0 0 0	
Cost Center Description BLDG & FIXT (SQUARE FEET) MVBLE EQUIP (DOLLAR VALUE) EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) Reconciliatio n ADMINISTRATIV E & GENERAL (ACCUM. COST) 95.00 09500 AMBULANCE SERVICES 0 0 0 0	
(SQUARE FEET) (DOLLAR VALUE) BENEFITS DEPARTMENT (GROSS SALARI ES) n E & GENERAL (ACCUM. COST) 1.00 2.00 4.00 5A 5.00 95.00 09500 AMBULANCE SERVICES 0 0 0 0	
(SQUARE FEET) (DOLLAR VALUE) BENEFITS DEPARTMENT (GROSS SALARI ES) n E & GENERAL (ACCUM. COST) 1.00 2.00 4.00 5A 5.00 95.00 09500 AMBULANCE SERVICES 0 0 0 0	
VALUE) DEPARTMENT (GROSS SALARI ES) (ACCUM. COST) 1.00 2.00 4.00 5A 5.00 95.00 09500 AMBULANCE SERVICES 0 0 0 0	
Image: Weight of the services Image: Constraint of the services Constraint of the services	
Image: Solution of the services Solution of the services <ths< td=""><td></td></ths<>	
1.00 2.00 4.00 5A 5.00 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 0	
95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0	
	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0	96.00
	97.00
	99.00
	99.10
	00.00
101. 00 10100 HOME HEALTH AGENCY 0 25, 196 2, 782, 686 0 4, 054, 723 1	
SPECIAL PURPOSE COST CENTERS	511.00
	05.00
	06.00
	07.00
	08.00
	09.00
	10.00
	11.00
	13.00
	14.00
	15.00
	16.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 449,963 13,557,008 84,921,526 -32,326,921 186,588,1281	
NONREI MBURSABLE COST CENTERS	10.00
	90.00
191. 00 19100 RESEARCH 0 1, 872 47, 797 0 63, 545 1	
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES 3, 261 430, 327 36, 133, 180 0 50, 651, 513 1	
192. 01 19201 OTHER NRCC 4, 600 5, 977 460, 448 0 5, 676, 9501	
192. 02 19202 LTC 0 5, 179 11, 346, 870 0 29, 629, 1891	
	93.002
193. 00 19300 NON ALD WORKERS 1940 1730 0 1, 172, 101 1	
	00.00
	00.00
202.00 Cost to be allocated (per Wkst. B, 9, 168, 861 9, 967, 145 5, 590, 823 32, 326, 921 2	
Part I)	JZ. 00
203.00 Unit cost multiplier (Wkst. B, Part I) 19.960425 0.711839 0.042029 0.1180762	03.00
204.00 Cost to be allocated (per Wkst. B, 219,790 4,244,046	04.00
Part II) Unit cost multiplier (Wkst. B, Part 0.001652 0.015502.2	05.00

IST A	LLOCATION - STATISTICAL BASIS		Provi der	F	Period: rom 01/01/2015	Worksheet B-1	
				T	o 12/31/2015	Date/Time Prep 5/27/2016 2:52	
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1
00	00200 CAP REL COSTS-MVBLE EQUIP						2
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4
00	00500 ADMI NI STRATI VE & GENERAL						5
00	00600 MAINTENANCE & REPAIRS	0	447.005				6
00 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	417, 885 6, 545				7
00	00900 HOUSEKEEPING	0	1, 654				9
	01000 DI ETARY	0	2, 530			180, 498	10
00	01100 CAFETERI A	0	14, 352	C	14, 352	0	11
	01200 MAINTENANCE OF PERSONNEL	0	0	C	-	0	12
	01300 NURSI NG ADMI NI STRATI ON	0	0		-		13
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	16, 302 3, 820	634		0	14 15
	01600 MEDI CAL RECORDS & LI BRARY	0				ő	16
	01700 SOCI AL SERVI CE	0		C		0	17
<i>c</i> -	INPATIENT ROUTINE SERVICE COST CENTERS						-
	03000 ADULTS & PEDIATRICS	0				161, 427	30
	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	13, 210	67,046		7, 740	31
	03300 BURN I NTENSI VE CARE UNI T	0	0		-	0	33
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	C	0	0	34
	04000 SUBPROVI DER – I PF	0	0	C	0	0	40
	04100 SUBPROVI DER - I RF	0	0	C	-	0	41
	04200 SUBPROVI DER 04300 NURSERY	0	0 3, 278	0 19, 627		0 4, 863	42
	04400 SKI LLED NURSI NG FACI LI TY	0	3,270	19,027		4, 803	43
	04500 NURSING FACILITY	0	0			ő	45
	04600 OTHER LONG TERM CARE	0	0	C	0	0	46
	ANCI LLARY SERVI CE COST CENTERS		1				
	05000 OPERATING ROOM	0					50
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0 25, 956	40, 826	-	0 4, 116	51 52
	05300 ANESTHESI OLOGY	0	23, 730	40, 020	0	4, 110	53
	05400 RADI OLOGY-DI AGNOSTI C	0	28, 488	97, 860	28, 488	89	54
	05500 RADI OLOGY-THERAPEUTI C	0	0	C	0	0	55
	05600 RADI OI SOTOPE 05700 CT SCAN	0	0	10.000	-	0 28	56 57
	05800 MRI	0	3, 593 1, 644			20	58
	05900 CARDI AC CATHETERI ZATI ON	0					59
	06000 LABORATORY	0		49		0	60
	06001 BLOOD LABORATORY	0	0	C	0 0	0	60
	06100 PBP CLINICAL LAB SERVICES-PRGM 06200 WHOLE BLOOD & PACKED RED BLOOD	0				0	61 62
	06300 BLOOD STORING PROCESSING & TRA	0				0	63
	06400 I NTRAVENOUS THERAPY	0	0		0	Ő	64
. 00	06500 RESPI RATORY THERAPY	0	2, 371	C	2, 371	0	65
	06600 PHYSI CAL THERAPY	0	325	45, 982		0	66
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0 575		0 0	0	67
	06900 ELECTROCARDI OLOGY		575 9, 049) 575 9,049	0	68 69
	07000 ELECTROENCEPHALOGRAPHY	0	7, 140			0	70
	07001 SLEEP DI SORDER	0	3, 905				70
	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	C	0	0	71
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0			0	73
	07500 ASC (NON-DISTINCT PART)	0	0			0	75
	03950 NUTRI TI ON/DI ABETES	0	0	C C	0	0	76
	07697 CARDI AC REHABI LI TATI ON	0	3, 593	С С	3, 593	0	76
~~	OUTPATIENT SERVICE COST CENTERS	-	-	-			
	08800 RURAL HEALTH CLINIC	0	0		0	0	88
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC		5, 631	6, 035	5, 631	5	89 90
	09100 EMERGENCY	0	28, 910			1, 966	91
	09200 OBSERVATION BEDS (NON-DISTINCT					.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	92
	OTHER REIMBURSABLE COST CENTERS		1	1			
	09400 HOME PROGRAM DI ALYSI S	0	0	C	0	0	94
. 00	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	95 96
00							

 90.00
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 EQUIP-RENTLD

 97.00
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Health Financial Systems FLO	YD MEMORIAL HOSP	PITAL & HEALTH	SVS	Inlie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS				Period:	Worksheet B-1	
				rom 01/01/2015		
			٦ [o 12/31/2015		
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	5/27/2016 2:5 DI ETARY	2 pm
cost center bescription	REPAIRS	PLANT	LINEN SERVICE		(MEALS	
	(SQUARE FEET)		(POUNDS OF	(SQUARE ILLI)	SERVED)	
			LAUNDRY)		JERVED)	
	6.00	7.00	8.00	9.00	10.00	
99.00 09900 CMHC	0	0				99.00
99. 10 09910 CORF	0	0		0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0		101.00
SPECIAL PURPOSE COST CENTERS						1
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0) (0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0 0	0	107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0) (0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0) (0 0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0) (0 0	0	111.00
113.0011300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0) (0 0	0	115.00
116. 00 11600 HOSPI CE	0	0) (0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	408, 496	1, 550, 041	400, 297	180, 498	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0) (0 0		190.00
191. 00 19100 RESEARCH	0	0) (, v		191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	3, 261				192.00
192.01 19201 OTHER NRCC	0	4, 600				192.01
192. 02 19202 LTC	0	0) (, i i i i i i i i i i i i i i i i i i i		192.02
193.00 19300 NONPALD WORKERS	0	0) (, v		193.00
194. 00 07950 MARKETI NG	0	1, 528	6 (1, 528	0	194.00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	0	10, 717, 986	1, 451, 255	3, 099, 353	3, 253, 612	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	·				18.025751	
204.00 Cost to be allocated (per Wkst. B,	0	2, 750, 045	191, 656	100, 538	377, 250	204.00
Part II)	0.000000		0 40001	0.045.000	0.000051	0.05 0.0
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	6. 580866	0. 122817	0. 245403	2.090051	205.00
11)	I	I	I	1		I

ealth Financial Systems FLC OST ALLOCATION - STATISTICAL BASIS	YD MEMORIAL HOSF		CCN: 150044	Period: From 01/01/2015	u of Form CMS-2 Worksheet B-1	
				To 12/31/2015	Date/Time Pre	
Cost Center Description	CAFETERI A (PRODUCTI VE HOURS)	MAI NTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSI NG ADMI NI STRATI N (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	5/27/2016 2: 5 PHARMACY (COSTED REQUI S.)	
	11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS		1	1			1 1 0
.00 00100 CAP REL COSTS-BLDG & FIXT .00 00200 CAP REL COSTS-MVBLE EQUIP .00 00400 EMPLOYEE BENEFITS DEPARTMENT .00 00500 ADMI NI STRATI VE & GENERAL .00 00600 MAI NTENANCE & REPAI RS .00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 0.00 01000 DI ETARY 1.00 01100 CAFETERIA 2.00 01200 MAI NTENANCE OF PERSONNEL 3.00 01300 NURSI NG ADMI NI STRATI ON 4.00 01400 CENTRAL SERVICES & SUPPLY 5.00 01500 PHARMACY 6.00 01600 MEDI CAL RECORDS & LI BRARY 7.00 NDATI ENT DOUTINE SERVICE COST	2, 447, 770 0 66, 236 74, 151 154, 066 0			0 0 28, 736, 984 0 0 0 0 0 0	1, 000 0 0	1. C 2. C 4. C 5. C 6. C 7. C 8. C 9. C 10. C 11. C 12. C 13. C 14. C 15. C 16. C
INPATIENT ROUTINE SERVICE COST CENTERS	776, 292		1	0 0	0	1 20 0
00.00 03000 ADULTS & PEDIATRICS 11.00 03100 INTENSIVE CARE UNIT 12.00 03200 CORONARY CARE UNIT 13.00 03300 BURN INTENSIVE CARE UNIT 14.00 03400 SURGICAL INTENSIVE CARE UNIT 0.00 04000 SUBPROVIDER - IPF 1.00 04100 SUBPROVIDER - IRF	776, 292 94, 878 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		30. 0 31. 0 32. 0 33. 0 34. 0 40. 0 41. 0
2. 00 04200 SUBPROVI DER 3. 00 04300 NURSERY 4. 00 04400 SKI LLED NURSI NG FACI LI TY	0 24, 772 0			0 0 0 0 0 0	0 0 0	42.0 43.0 44.0
5. 00 04500 NURSI NG FACILITY 6. 00 04600 OTHER LONG TERM CARE	0			0 0 0 0	0	45.0
ANCILLARY SERVICE COST CENTERS			1			
00.00 05000 0PERATING ROOM 11.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY-THERAPEUTI C 66.00 05600 RADI OLOGY-THERAPEUTI C 77.00 05700 CT SCAN 88.00 05800 MRI 99.00 05900 CARDI AC CATHETERI ZATI ON 60.00 LABORATORY 06001 11.00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM	245, 530 0 43, 755 0 134, 643 0 20, 511 11, 693 81, 804 160, 797 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD 3.00 06300 BLOOD STORING PROCESSING & TRA 4.00 06400 INTRAVENOUS THERAPY 5.00 06500 RESPI RATORY THERAPY 5.00 06600 PHYSI CAL THERAPY 5.00 06600 PHYSI CAL THERAPY 5.00 06600 SPEECH PATHOLOGY 9.00 06800 SPEECH PATHOLOGY 9.00 06900 ELECTROCARDI OLOGY 9.00 07000 ELECTROCARDI OLOGY 9.00 07001 SLEEP DI SORDER 1.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI 2.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 3.00 07300 DRUGS CHARGED TO PATI ENTS 3.00 07400 RENAL DI ALYSI S 5.00 07500 ASC (NON-DI STINCT PART)	0 0 78, 688 51, 802 0 5, 286 58, 975 2, 749 23, 415 0 0 0 0 0 0			0 0 0 0 12, 242, 593 0 16, 494, 391 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 1,000 0 0 0 0 0 0 0 0	62.0 63.0 64.0 65.0 67.0 68.0 70.0 70.0 71.0 72.0 73.0 74.0
6. 00 03950 NUTRI TI ON/DI ABETES	0			o o	0	76.0
6. 97 07697 CARDI AC REHABI LI TATI ON	7, 378	C		0 0	0	76. 9
OUTPATIENT SERVICE COST CENTERS 0.0800 RURAL HEALTH CLINIC 0.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.00 09000 CLINIC 0.00 09100 EMERGENCY 2.00 09200 OBSERVATION BEDS (NON-DISTINCT	0 0 18, 358 145, 532			0 0 0 0 0 0 0 0	0 0 0 0	88. 89. 90. 91. 92.
OTHER REIMBURSABLE COST CENTERS		1	1			
4. 00 09400 HOME PROGRAM DI ALYSI S 5. 00 09500 AMBULANCE SERVI CES 6. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	000000000000000000000000000000000000000			0 0 0 0 0 0	0	

113.00 11300 INTEREST EXPENSE 113.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 100 0 0 0 0 114.00 114.00 114.00 114.00 114.00 100 0 0 0 0 0 114.00 100 114.00 114.00 114.00 114.00 104.00 0 0 0 0 0 0 0 0 0 0 0 116.00 100 0 0 0 0 0 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00	Health Financial Systems FLOYE	MEMORIAL HOSP	ITAL & HEALTH	SVS	In Lie	u of Form CMS-2	2552-10
Cost Center Description CAFETERIA (PRODUCTIVE HOURS) MAINTENANCE (PRODUCTIVE HOURS) NURSING (PROT HOURS) NURSING (COSTED RESULS.) DeterTime Prepare SZV/2016.2 :52. pm (COSTED REQUIS.) 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 11. 00 12. 00 13. 00 14. 00 15. 00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0	COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150044		Worksheet B-1	
Cost Center Description CAFETERIA (PRODUCTIVE HOURS) MURSING OF PERSONAL MURSING ADMINISTRATIO SERVICES & SERVICES & (COSTED REOUIS.) 97.00 00700 DURABLE MEDICAL EQUIP-SOLD 0 <td></td> <td></td> <td></td> <td></td> <td>From 01/01/2015</td> <td>Data /Tima Dros</td> <td>narod.</td>					From 01/01/2015	Data /Tima Dros	narod.
Cost Center Description CAFETERIA (PRODUCTIVE HOURS) MAI NTERINCE (PRODUCTIVE HOURS) NMI NTERINCE (PRODUCTIVE (NUMBED) NUMI NTERINC NUMI NTERINC (NUMBED) CENTRAL SERVICES PHARMACY REQUIS.) 97.00 09700 DURABLE MEDI CAL EQUIP-SOLD 0 11.00 12.00 13.00 14.00 15.00 97.00 97.00 09700 DURABLE MEDI CAL EQUIP-SOLD 0 0 0 0 0 0 97.00 97.00 00 0 0 0 0 0 97.00 97.00 0					10 12/31/2015	5/27/2016 2:52	
Hours Hours (Hours) (Hours) N Supply (Correct (Correct) REQUIS.) 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 11.00 12.00 13.00 14.00 15.00 97.00 99.10 09700 CORRECT 0 0 0 0 0 97.00 97.00 0 0 0 0 97.00 97.00 00.00 0 0 0 0 0 97.00 97.00 0	Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL		
HOUSED HOUSED (DI RECT NRSI NG HRS) (COSTED REQUIS.) 97. 00 09700 DURABLE MEDI CAL EQUIP-SOLD 0 0 11. 00 12. 00 13. 00 14. 00 15. 00 97. 00 09900 CMARC 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 99. 10. 00 10000 10000 13. 00 0 0 0 0 99. 10. 00 10000 13. 886 0		(PRODUCTI VE	OF PERSONNEL	ADMI NI STRATI	0 SERVICES &	(COSTED	
Image: Normal State NRESING HRS3 RÉQUIS.) 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 <		HOURS)				REQUIS.)	
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97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0				,	,		
99.00 09900 CMHC 0 0 0 0 0 99.9 99.10 00910 CORF 0 0 0 0 0 0 0 99.9 100.00 10000 IAR SERVICES-NOT APPRVD PRGM 0<							
99.10 09910 CORF 0 <t< td=""><td></td><td>0</td><td>0</td><td>)</td><td>0 0</td><td>-</td><td></td></t<>		0	0)	0 0	-	
100.00 10000 JAR SERVICES-NOT APPROD PRGM 0 <		0	0)	0 0	-	
101:00 10100 HOME HEALTH ACENCY 83,886 0 0 0 0 101. SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTER (D.P.) O O SPECIAL PURPOSE COST CENTER (D.P.) O SPECIAL PURPOSE COST CENTER (D.P.) O O O O O O O O O O O O		0			0 0		
SPECIAL PURPOSE COST CENTERS Image: Cost of the content		02 004			0 0		
105.00 10500 KIDNEY ACQUISITION 0 <td></td> <td>83,880</td> <td>0</td> <td>/</td> <td>0 0</td> <td>0</td> <td>101.00</td>		83,880	0	/	0 0	0	101.00
106.00 10600 HEART ACQUISITION 0 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>105 00</td>		0	0		0 0	0	105 00
107.00 10700 LIVER ACQUISITION 0 110.0 111.0 0 111.0 0 111.0 0 111.0 0 111.0 0 111.0 0 114.0 0 114.0 0 114.0 0 114.0 0 114.0 0 114.0 0 114.0 0 114.0 0 114.0 0 114.0 0 114.0 0 0 0 0 0 0 0 <		0					
108.00 108.00 LUNG ACQUI SI TI ON 0		0					
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114.00 11400 UTILIZATION REVIEW-SNF 114. 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 115. 116.00 11600 HOSPICE 0 0 0 0 0 116. 118.00 SUBTOTALS (SUM OF LINES 1-117) 2,365,197 0 0 28,736,984 1,000 116. NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 0 0 0 190. 191.00 19200 PHSICIANS PRIVATE OFFICES 71,159 0 0 0 192. 192.00 192.01 THER NRCC 5,477 0 0 0 192. 192.02 172.02 192.02 172.02 192.02 192.02 192.01 0 0 0 0 192.02 192.02 192.02 192.02 172.0 0 0 0 0 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.02 0 0 0		_			-		113.00
116.00 11600 HOSPICE 0 0 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 2,365,197 0 0 28,736,984 1,000 118. NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 190.01 190.01 191.00 191.00 191.00 191.00 RESEARCH 1,875 0 0 0 0 0 191.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 0							114.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 2, 365, 197 0 0 28, 736, 984 1, 000 118. NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 0 0 0 190. 191.00 19200 PHYSI CI ANS PRI VATE OFFICES 71, 159 0 0 0 191. 192.01 19201 OTHER NRCC 5, 477 0 0 0 192. 192.02 19202 LTC 0 0 0 0 192. 192.02 19202 LTC 0 0 0 0 192. 193.00 19300 NONPAI D WORKERS 0 0 0 0 193. 194.00 O7950 MARKETI NG 4, 062 0 0 0 194. 200.00 Cross Foot Adj ustments - - 201. 201. 201. 202.00 Cost to be all ocated (per Wkst. B, Part I) 0.325593 0.000000	115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
NONRE IMBURSABLE COST CENTERS 190.00 GIFT FLOWER COFFEE SHOP & CAN 0 0 0 0 190.00 191.00 19100 RESEARCH 1,875 0 0 0 0 191.00 192.00 PHYSI CI ANS PRI VATE OFFICES 71,159 0 0 0 192.01 192.01 19200 OTHER NRCC 5,477 0 0 0 192.01 192.02 19202 LTC 0 0 0 0 192.01 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.02 193.00 19300 NARKETI NG 4,062 0 0 0 193.02	116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
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191.00 19100 RESEARCH 1,875 0 0 0 191. 192.00 19200 PHYSI CI ANS PRI VATE OFFICES 71,159 0 0 0 192. 192.01 19201 OTHER NRCC 5,477 0 0 0 192. 192.02 19202 LTC 0 0 0 0 192. 193.00 19300 NONPAI D WORKERS 0 0 0 0 193. 194.00 07950 MARKETI NG 4,062 0 0 0 194. 200.00 Cross Foot Adj ustments 4,062 0 0 0 194. 201.00 Negati ve Cost Centers 200. 200. 201. 200. 201. 202.00 Cost to be al located (per Wkst. B, Part I) 0.325593 0.000000 0.000000 0.138345 4,536.587000 203. 204.00 Cost to be al located (per Wkst. B, 388,884 0 0 536,494 207,516 204.							
192.00 PHYSICIANS PRIVATE OFFICES 71,159 0 0 0 192.01 192.01 19201 OTHER NRCC 5,477 0 0 0 192.01 192.02 19202 LTC 0 0 0 0 192.01 192.02 19202 LTC 0 0 0 0 192.01 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.01 194.00 07950 MARKETI NG 4,062 0 0 0 194.200.00 200.00 Cross Foot Adj ustments 4,062 0 0 0 194.200.00 201.00 Negati ve Cost Centers 200.200 201.200.200 201.200.200.200.200.200.200.200.200.200.		-					
192.01 19201 OTHER NRCC 5,477 0 0 0 192. 192.02 19202 LTC 0 0 0 0 192. 193.00 19300 NONPAI D WORKERS 0 0 0 0 193. 194.00 07950 MARKETI NG 4,062 0 0 0 194. 200.00 Cross Foot Adj ustments 4,062 0 0 0 194. 200.00 Cross Foot Adj ustments 200.					0 0		
192.02 LTC 0 0 0 0 192.02 193.00 19300 NONPAID WORKERS 0 0 0 0 193.00 193.00 193.00 193.00 193.00 0 0 0 193.00 193.00 193.00 193.00 0 0 0 0 193.00 193.00 193.00 193.00 193.00 0 0 0 193.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00					0 0		
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200.00 Cross Foot Adjustments 200.00 201.00 202.00		0	0)	0 0		
201.00 Negative Cost Centers 201. 202. 201. 202. 20		4,062	0)	0 0		
202.00 Cost to be allocated (per Wkst. B, Part I) 796,976 0 3,975,612 4,536,587 202. 203.00 Unit cost multiplier (Wkst. B, Part I) 0.325593 0.000000 0.000000 0.138345 4,536,587000 203. 204.00 Cost to be allocated (per Wkst. B, 388,884 0 0 0 536,494 207,516 204.							
Part I) Part I) 0.325593 0.00000 0.000000 0.138345 4,536.587000 203. 204.00 Cost to be allocated (per Wkst. B, 388,884 0 0 0 536,494 207,516 204.		704 074			0 2 075 (12		
204.00 Cost to be allocated (per Wkst. B, 388,884 0 0 536,494 207,516 204.	Part I)						
				0. 00000			
Part II)	204.00 Cost to be allocated (per Wkst. B, Part II)	388, 884	0)	0 536, 494	207, 516	204.00
205.00 Unit cost multiplier (Wkst. B, Part 0.158873 0.000000 0.000000 0.018669 207.516000 205.	205.00 Unit cost multiplier (Wkst. B, Part	0. 158873	0. 000000	0. 00000	0. 018669	207. 516000	205.00

T ALLOCATION - STATISTICAL BASIS		i i ovrači		01/01/2015 12/31/2015 Date/Time Prep	
Cost Center Description	MEDI CAL	SOCI AL	L_,	5/27/2016 2:52	<u>' pm</u>
	RECORDS & LI BRARY	SERVICE (TIME SPENT)			
	(TIME SPENT) 16.00	17.00			
GENERAL SERVICE COST CENTERS	10.00	17.00			
0 00100 CAP REL COSTS-BLDG & FIXT					1.
00 00200 CAP REL COSTS-MVBLE EQUIP 00 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 4.
0 00500 ADMI NI STRATI VE & GENERAL					5.
00 00600 MAINTENANCE & REPAIRS					6.
00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE					7. 8.
0 00900 HOUSEKEEPI NG					9.
00 01000 DI ETARY 00 01100 CAFETERIA					10. 11.
00 01200 MAINTENANCE OF PERSONNEL					12.
00 01300 NURSING ADMINISTRATION					13.
00 01400 CENTRAL SERVICES & SUPPLY 00 01500 PHARMACY					14. 15.
00 01600 MEDICAL RECORDS & LIBRARY	1, 378				16.
00 01700 SOCIAL SERVICE	0	0			17.
INPATIENT ROUTINE SERVICE COST CENTERS 00 03000 ADULTS & PEDIATRICS	1, 228	0			30.
00 03100 I NTENSI VE CARE UNI T	0	0			30. 31.
00 03200 CORONARY CARE UNIT	0	0			32.
00 03300 BURN INTENSIVE CARE UNIT 00 03400 SURGICAL INTENSIVE CARE UNIT	0	0			33. 34.
00 04000 SUBPROVIDER - IPF	0	0			40.
00 04100 SUBPROVIDER - IRF	0	0			41.
00 04200 SUBPROVI DER 00 04300 NURSERY	0	0			42. 43.
00 04400 SKILLED NURSING FACILITY	0	0			44.
00 04500 NURSING FACILITY	0	0			45.
00 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0			46.
00 05000 OPERATI NG ROOM	90	0			50.
00 05100 RECOVERY ROOM 00 05200 DELIVERY ROOM & LABOR ROOM	0	0			51. 52.
00 05300 ANESTHESI OLOGY	0	0			52.
00 05400 RADI OLOGY-DI AGNOSTI C	5	0			54.
00 05500 RADI OLOGY-THERAPEUTI C 00 05600 RADI OI SOTOPE	0	0			55. 56.
00 05700 CT SCAN	0	0			57.
00 05800 MRI	0	0			58.
00 05900 CARDI AC CATHETERI ZATI ON 00 06000 LABORATORY	0	0			59. 60.
01 06001 BLOOD LABORATORY	0	0			60.
00 06100 PBP CLINICAL LAB SERVICES-PRGM					61.
00 06200 WHOLE BLOOD & PACKED RED BLOOD 00 06300 BLOOD STORING PROCESSING & TRA	0	0			62. 63.
00 06400 I NTRAVENOUS THERAPY	0	0			64.
00 06500 RESPI RATORY THERAPY 00 06600 PHYSI CAL THERAPY	7	0			65. 66.
00 06700 OCCUPATIONAL THERAPY	0	0			67.
00 06800 SPEECH PATHOLOGY	0	0			68.
00 06900 ELECTROCARDI OLOGY 00 07000 ELECTROENCEPHALOGRAPHY	5	0			69. 70.
01 07001 SLEEP DI SORDER	0	0			70.
00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0			71.
00 07200 I MPL. DEV. CHARGED TO PATIENTS 00 07300 DRUGS CHARGED TO PATIENTS	0	0			72. 73.
00 07400 RENAL DI ALYSI S	0	0			74.
00 07500 ASC (NON-DI STI NCT PART)	0	0			75.
00 03950 NUTRI TI ON/DI ABETES 97 07697 CARDI AC REHABI LI TATI ON	0	0			76. 76.
OUTPATIENT SERVICE COST CENTERS					, 0.
00 08800 RURAL HEALTH CLINIC	0	0			88.
00 08900 FEDERALLY QUALIFIED HEALTH CENTER 00 09000 CLINIC	0	0			89. 90.
00 09100 EMERGENCY	38	0			91.
00 09200 OBSERVATION BEDS (NON-DISTINCT					92.
OTHER REIMBURSABLE COST CENTERS 00 09400 HOME PROGRAM DIALYSIS	0	0			94.
00 09500 AMBULANCE SERVICES	0	0			95.
00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			96. 97.

er CCN: 150044 Period: Worksheet B-1 From 01/01/2015
To 12/31/2015 Date/Time Prep 5/27/2016 2:52
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COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 150044 Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I	
	Date/Time Pre 5/27/2016 2:5	pared:
Title XVIII Hospital	PPS	2 piii
Costs		
Cost Center DescriptionTotal Cost (from Wkst. B, Part I, col. 26)Therapy Limit Adj.Total Costs Disal Iowance	Total Costs	
1.00 2.00 3.00 4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		
30. 00 03000 ADULTS & PEDIATRICS 48, 263, 906 48, 263, 906 40, 413		
31. 00 03100 I NTENSI VE CARE UNI T 4, 945, 961 4, 945, 961 0		
32. 00 03200 CORONARY CARE UNIT 0 0 0	0	
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 34.00 03400 SURGI CAL INTENSIVE CARE UNIT 0 0 0	0	
34. 00 O3400 SURGI CAL INTENSI VE CARE UNIT 0 0 0 40. 00 O4000 SUBPROVI DER - I PF 0 0 0 0		
40.00 04000 SUBPROVIDER - I RF 0 0 0 0	0	
42. 00 04200 SUBPROVI DER 0 0 0	0	
43.00 04300 NURSERY 1, 402, 082 1, 402, 082 0	1, 402, 082	
44.00 04400 SKILLED NURSING FACILITY 0 0 0	0	
45.00 04500 NURSING FACILITY 0 0 0	0	45.00
46.00 04600 OTHER LONG TERM CARE 0 0 0	0	46.00
ANCI LLARY SERVICE COST CENTERS		
50. 00 05000 OPERATING ROOM 15, 485, 486 15, 485, 486 0		1
51.00 05100 RECOVERY ROOM 0 0 0	-	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 3, 441, 807 3, 441, 807 0		
53. 00 05300 ANESTHESI 0LOGY 0 0 0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 16, 852, 327 0		
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 56. 00 05600 RADI OI SOTOPE 0 0 0 0		
57. 00 05700 CT SCAN 1, 636, 449 1, 636, 449 0	-	1
58. 00 05800 MRI 988, 018 988, 018 0	988, 018	
59. 00 05900 CARDI AC CATHETERI ZATI ON 4, 059, 965 4, 059, 965 0		
60.00 06000 LABORATORY 13, 113, 378 13, 113, 378	13, 113, 378	
60. 01 06001 BLOOD LABORATORY 0 0 0	0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM 0 0 0	0	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD 0 0	0	
63. 00 06300 BLOOD STORING PROCESSING & TRA 0 0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 691, 850 691, 850 0	691, 850	64.00
65. 00 06500 RESPI RATORY THERAPY 3, 219, 587 0 3, 219, 587 0	3, 219, 587	65.00
66. 00 06600 PHYSI CAL THERAPY 5, 271, 370 0 5, 271, 370 0	5, 271, 370	
67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0	-	
68. 00 06800 SPEECH PATHOLOGY 344, 982 0 344, 982 0		
69. 00 06900 ELECTROCARDI 0LOGY 4, 300, 578 4, 300, 578 0	.,	1
70. 00 O7000 ELECTROENCEPHALOGRAPHY 492, 992 0 70. 01 07001 SLEEP DI SORDER 1, 335, 405 0	492, 992	
70. 01 07001 SLEEP DI SORDER 1, 335, 405 1, 335, 405 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 15, 381, 851 15, 381, 851 0		
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 20, 723, 893 20, 723, 893 0	20, 723, 893	1
73. 00 07300 DRUGS CHARGED TO PATI ENTS 31, 338, 226 31, 338, 226 0		
74. 00 07400 RENAL DI ALYSI S 0 0 0		74.00
75.00 07500 ASC (NON-DISTINCT PART) 0 0 0	0	75.00
76. 00 03950 NUTRI TI ON/DI ABETES 0 0 0	0	76.00
76. 97 O7697 CARDIAC REHABILITATION 793, 147 793, 147 0	793, 147	76.97
OUTPATIENT SERVICE COST CENTERS		
88.00 O8800 RURAL HEALTH CLINIC OOO		
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 90. 00 09000 CLINIC 1, 657, 553 1, 657, 553 0	-	
90. 00 09000 CLINIC 1,657,553 1,657,553 0 91. 00 09100 EMERGENCY 7,969,639 7,969,639 0	1, 657, 553 7, 969, 639	
91.00 O9100 Emercency 7,969,639 7,969,639 0 92.00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT 7,292,576 7,292,576 7 292,576 7	7, 969, 639	
OTHER REIMBURSABLE COST CENTERS	1,272,370	,2.00
94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES 0 0 0	0	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0	0	
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0	0	
99.00 09900 CMHC 0 0	0	99.00
99.10 09910 CORF 0 0	0	99.10
100.00 10000 I & SERVICES-NOT APPRVD PRGM 0 0		100.00
101.00 HOME HEALTH AGENCY 4, 560, 801 4, 560, 801	4, 560, 801	101.00
SPECIAL PURPOSE COST CENTERS		105
105. 00 10500 KI DNEY ACQUI SI TI ON 0 0		105.00
106. 00 10600 HEART ACQUI SI TI ON 0 0		106.00
107.00 10700 LI VER ACQUI SI TI ON 0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON 0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON 0 0 110.00 11000 INTESTI NAL ACQUI SI TI ON 0 0		109.00
111.00 11100 I SLET ACQUI SI TI ON 0 0		111.00
113. 00 11300 I NTEREST EXPENSE		113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		114.00
		115.00
115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0	(L)	

FLOYD MEMORIAL HOSPITAL & HEALTH SVS

In Lieu of Form CMS-2552-10

COMPUTATI ON	OF RATIO OF COSTS TO CHARGES				Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/27/2016 2:5	
			 Ti tl	e XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	apy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
116.0011600	HOSPICE	0			0	0	116.00
200.00 201.00 202.00	Subtotal (see instructions) Less Observation Beds Total (see instructions)	215, 563, 829 7, 292, 576 208, 271, 253	0	215, 563, 82 7, 292, 57 208, 271, 25	6	7, 292, 576	201.00

Health Financial Systems	FLOYD MEMORIAL HOSP	ITAL & HEALTH	SVS	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	F	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part L	epared.
			e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	<u>Charges</u> Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	49, 873, 417		49, 873, 417	7		30.00
31. 00 03100 I NTENSI VE CARE UNI T	7, 445, 862		7, 445, 862			31.00
32.00 03200 CORONARY CARE UNI T	0		()		32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0		0)		33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0		()		34.00
40. 00 04000 SUBPROVI DER - I PF	0)		40.00
41. 00 04100 SUBPROVI DER – I RF 42. 00 04200 SUBPROVI DER	0					41.00
43. 00 04300 NURSERY	2, 652, 367		2, 652, 367	7		43.00
44.00 04400 SKILLED NURSING FACILITY	0		(44.00
45.00 04500 NURSING FACILITY	0		0)		45.00
46.00 O4600 OTHER LONG TERM CARE	0		()		46.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM	66, 480, 326	66, 837, 902	133, 318, 228	0. 116154	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	00,400, 320	00,037,702) 155, 510, 220	0. 000000	0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	5, 094, 115	1, 041, 807	6, 135, 922	0. 560927	0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	C	(0. 000000	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	17, 056, 879	57, 562, 944	74, 619, 823		0.00000	
56. 00 05500 RADI OLOGY - THERAPEUTIC	0			0.000000 0.000000	0. 000000 0. 000000	
57. 00 05700 CT SCAN	17, 291, 327	29, 512, 952	46, 804, 279		0. 000000	
58. 00 05800 MRI	6, 620, 427	20, 380, 646	27, 001, 073	0. 036592	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	40, 299, 797	43, 403, 285			0.00000	
	46, 796, 648	53, 101, 573			0.00000	
60.01 06001 BLOOD LABORATORY 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM	0				0. 000000 0. 000000	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD	0	C			0. 000000	
63.00 06300 BLOOD STORING PROCESSING & TRA	0	C	0 0	0. 000000	0. 000000	
64. 00 06400 I NTRAVENOUS THERAPY	53, 691	3, 224, 693			0.00000	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	18, 558, 282 5, 278, 563	2, 837, 016 19, 537, 953			0. 000000 0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	5, 278, 505	19, 007, 900			0. 000000	
68.00 06800 SPEECH PATHOLOGY	815, 052	263, 945	1, 078, 997		0.000000	
69.00 06900 ELECTROCARDI OLOGY	17, 376, 805	37,097,290			0.00000	
70. 00 07000 ELECTROENCEPHALOGRAPHY 70. 01 07001 SLEEP DI SORDER	117, 640 149, 196	786, 603 9, 504, 826			0. 000000 0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	149, 190	9, 801, 903			0. 000000	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	13, 794, 044	6, 922, 335			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	50, 766, 121	86, 392, 482			0. 000000	1
74. 00 07400 RENAL DI ALYSI S	0	C			0.00000	
75. 00 07500 ASC (NON-DI STI NCT PART) 76. 00 03950 NUTRI TI ON/DI ABETES	0	C				
76. 97 07697 CARDI AC REHABI LI TATI ON	2,013	1, 491, 762				
OUTPATIENT SERVICE COST CENTERS	· · ·					
88. 00 08800 RURAL HEALTH CLINIC	0	C				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90.00 09000 CLINIC	2 0 684, 921	C 5, 472, 478		0. 269197	0. 000000	89.00 90.00
91. 00 09100 EMERGENCY	15, 138, 459	37, 054, 020			0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	1, 641, 321	7, 477, 593	9, 118, 914	0. 799720	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS				0 00000	0,00000	
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0	C		0. 000000 0. 000000	0. 000000 0. 000000	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0.000000	0. 000000	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C) (0. 000000	0. 000000	97.00
99.00 09900 CMHC	0	C) (99.00
99.10 09910 CORF 100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	C)		99.10 100.00
101.00 10100 HOME HEALTH AGENCY	0	5, 619, 278	5, 619, 278	3		101.00
SPECIAL PURPOSE COST CENTERS				-1		
105.00 10500 KIDNEY ACQUISITION	0	C				105.00
106. 00 10600 HEART ACQUI SI TI ON	0	C)		106.00
107. 00 10700 LIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION	0					107.00 108.00
109. 00 10900 PANCREAS ACQUISITION	0	0		Ď		108.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	C)		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	C	0 0)		111.00
113.00 11300 INTEREST EXPENSE 114.00 11400 UTI LI ZATI ON REVI EW-SNF						113.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C	0 0			114.00 115.00
116. 00 11600 HOSPI CE	0	C				116.00
5/27/2016 2:52 pm C:\MCRIF32\Flovd2015.mcrx	· · ·					

Health Fin	ancial Systems	FLOYD MEMORIAL HOSP	ITAL & HEALTH	SVS	In Lie	u of Form CMS-	-2552-10
COMPUTATIO	ON OF RATIO OF COSTS TO CHARGES		Provi der		Period:	Worksheet C	
_					From 01/01/2015 To 12/31/2015		epared: 52 pm
			Ti tl	e XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
200.00	Subtotal (see instructions)	398, 326, 299	505, 325, 286	903, 651, 58	5		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	398, 326, 299	505, 325, 286	903, 651, 58	5		202.00

Health Financial Systems	FLOYD MEMORIAL HOSPITA	AL & HEALTH SVS	In Lieu of Form CMS	S-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150044	Period: Worksheet C From 01/01/2015 Part I To 12/31/2015 Date/Time P	repared:
		Title XVIII	5/27/2016 2 Hospi tal PPS	
Cost Center Description	PPS Inpatient Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 I NTENSI VE CARE UNI T				31.00
32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT				32.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT				33.00 34.00
40. 00 04000 SUBPROVIDER - 1 PF				40.00
41. 00 04100 SUBPROVI DER - I RF				41.00
42. 00 04200 SUBPROVI DER				42.00
43.00 04300 NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY				44.00
45.00 04500 NURSING FACILITY				45.00
46.00 04600 OTHER LONG TERM CARE				46.00
ANCI LLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 116154			50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000 0. 560927			51.00 52.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0. 000000			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 225842			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
56. 00 05600 RADI OI SOTOPE	0. 000000			56.00
57.00 05700 CT SCAN	0. 034964			57.00
58.00 05800 MRI	0. 036592			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 048504			59.00
60. 00 06000 LABORATORY	0. 131267			60.00
60.01 06001 BLOOD LABORATORY	0. 000000			60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM	0. 000000			61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD	0. 000000			62.00
63.00 06300 BLOOD STORING PROCESSING & TRA 64.00 06400 INTRAVENOUS THERAPY	0.000000			63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0. 211034 0. 150481			64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0. 212414			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68.00 06800 SPEECH PATHOLOGY	0. 319725			68.00
69.00 06900 ELECTROCARDI OLOGY	0. 078947			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 545199			70.00
70. 01 07001 SLEEP DI SORDER	0. 138326			70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 637169			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	1. 000363			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0. 228482 0. 000000			73.00 74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			74.00
76. 00 03950 NUTRI TI ON/DI ABETES	0. 000000			76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 530968			76.97
OUTPATIENT SERVICE COST CENTERS	i			
88.00 08800 RURAL HEALTH CLINIC				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90. 00 09000 CLINIC	0. 269197			90.00
91.00 09100 EMERGENCY	0. 152697			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT	0. 799720			92.00
94.00 09400 HOME PROGRAM DI ALYSI S	0. 000000			94.00
95.00 09500 AMBULANCE SERVICES	0. 000000			94.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97.00
99. 00 09900 CMHC				99.00
99. 10 09910 CORF				99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM				100.00
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				105 00
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON				105.00 106.00
107. 00 10700 LIVER ACQUISITION				108.00
108. 00 10800 LUNG ACQUI SI TI ON				107.00
109. 00 10900 PANCREAS ACQUI SI TI ON				109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON				110.00
111. 00 11100 SLET ACQUI SI TI ON				111.00
113.00 11300 INTEREST EXPENSE				113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)			115.00
116.00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
5/27/2016 2.52 pm C:\MCRLE32\ELovd2015 mcrx				

Health Financial Systems	FLOYD MEMORIAL HOSPI	TAL & HEALTH SVS	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150044	Period: From 01/01/2015	Worksheet C	
				Date/Time Pre	
				5/27/2016 2:5	z pili
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
202.00 Total (see instructions)					202.00

Health Fina	ancial Systems	FLOYD MEMORIAL HOSP	ITAL & HEALTH	SVS	In Lie	u of Form CMS-	2552-10
	N OF RATIO OF COSTS TO CHARGES		Provi der	F	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/27/2016 2:5	epared:
			Tit	le XIX	Hospi tal	Cost	52 pili
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	ATIENT ROUTINE SERVICE COST CENTERS		I				
	DO ADULTS & PEDIATRICS	48, 263, 906		48, 263, 906		48, 304, 319	
	DO INTENSIVE CARE UNIT	4, 945, 961		4, 945, 961	0	4, 945, 961	
	CORONARY CARE UNIT	0			0	0	
	DO BURN INTENSIVE CARE UNIT	0			0	0	
	DO SURGICAL INTENSIVE CARE UNIT	0			0	0	
	DO SUBPROVIDER - IPF	0			0	0	
	00 SUBPROVI DER – I RF	0			0	0	
		1 402 002			0	0	
	DO NURSERY DO SKILLED NURSING FACILITY	1, 402, 082		1, 402, 082	0	1, 402, 082 0	
	DO NURSING FACILITY	0			0	0	
	DO OTHER LONG TERM CARE	0				0	
	LLARY SERVICE COST CENTERS		I		0	0	40.00
	DO OPERATI NG ROOM	15, 485, 486		15, 485, 486	0	15, 485, 486	50.00
	DO RECOVERY ROOM	0			0	0	
	DO DELIVERY ROOM & LABOR ROOM	3, 441, 807		3, 441, 807	-	3, 441, 807	
	DO ANESTHESI OLOGY	0,, 00,		_,, 30,	0	0,111,007	
	DO RADI OLOGY-DI AGNOSTI C	16, 852, 327		16, 852, 327	0	16, 852, 327	
	DO RADI OLOGY-THERAPEUTI C	0		C	0	0	
56.00 0560	DO RADI OI SOTOPE	0		l c	0 0	0	56.00
57.00 0570	DO CT SCAN	1, 636, 449		1, 636, 449	0	1, 636, 449	57.00
58.00 0580	DO MRI	988, 018		988, 018	0	988, 018	58.00
59.00 0590	DO CARDI AC CATHETERI ZATI ON	4, 059, 965		4, 059, 965	0	4, 059, 965	59.00
60.00 0600	DO LABORATORY	13, 113, 378		13, 113, 378	8 0	13, 113, 378	60.00
60.01 0600	D1 BLOOD LABORATORY	0		C	0 0	0	60.01
61.00 0610	DO PBP CLINICAL LAB SERVICES-PRGM	0		C	0	0	61.00
	00 WHOLE BLOOD & PACKED RED BLOOD	0		C	0 0	0	62.00
	DO BLOOD STORING PROCESSING & TRA	0		C	0 0	0	63.00
	DO INTRAVENOUS THERAPY	691, 850		691,850	0 0	691, 850	64.00
	00 RESPI RATORY THERAPY	3, 219, 587	C			3, 219, 587	
	DO PHYSI CAL THERAPY	5, 271, 370	C	5, 271, 370	0 0	5, 271, 370	
	OO OCCUPATI ONAL THERAPY	0	C	C	0	0	
	DO SPEECH PATHOLOGY	344, 982		344, 982		344, 982	
		4, 300, 578		4, 300, 578		4, 300, 578	
		492, 992		492, 992		492, 992	
	DI SLEEP DI SORDER	1, 335, 405		1, 335, 405		1, 335, 405 15, 381, 851	
	DO MEDICAL SUPPLIES CHARGED TO PAT DO IMPL. DEV. CHARGED TO PATIENTS	15, 381, 851 20, 723, 893		15, 381, 851 20, 723, 893		20, 723, 893	
	DO DRUGS CHARGED TO PATTENTS	31, 338, 226		31, 338, 226		31, 338, 226	
	DO RENAL DI ALYSI S	51, 550, 220		51, 550, 220			74.00
	DO ASC (NON-DI STINCT PART)	0			0	0	
	50 NUTRI TI ON/DI ABETES	0			0	0	
	27 CARDI AC REHABI LI TATI ON	793, 147		793, 147	0	793, 147	
	PATIENT SERVICE COST CENTERS						1
88.00 0880	DO RURAL HEALTH CLINIC	0		C	0 0	0	88.00
	DO FEDERALLY QUALIFIED HEALTH CENTER	0		C	0 0	0	89.00
	DO CLINIC	1, 657, 553		1, 657, 553		1, 657, 553	
	DO EMERGENCY	7, 969, 639		7, 969, 639		7, 969, 639	
	OO OBSERVATION BEDS (NON-DISTINCT	7, 292, 576		7, 292, 576)	7, 292, 576	92.00
	R REIMBURSABLE COST CENTERS						
	DO HOME PROGRAM DI ALYSI S	0			0	0	
	DO AMBULANCE SERVICES	0			0	0	
	DO DURABLE MEDICAL EQUIP-RENTED DO DURABLE MEDICAL EQUIP-SOLD	0			0	0	
		0			0	0	
99.00 0990 99.10 0991		0				0	1
	DO I &R SERVICES-NOT APPRVD PRGM	0				-	100.00
	DO HOME HEALTH AGENCY	4, 560, 801		4, 560, 801	,	4, 560, 801	
	CIAL PURPOSE COST CENTERS	4, 300, 001		4, 300, 001		4, 300, 001	101.00
	DO KIDNEY ACQUISITION	0		0)	0	105.00
	DO HEART ACQUI SI TI ON	0)		106.00
	DO LIVER ACQUISITION	0		r)		107.00
	DO LUNG ACQUI SI TI ON	0)		108.00
	DO PANCREAS ACQUI SI TI ON	0)		109.00
	DO INTESTINAL ACQUISITION	0)		110.00
	DO I SLET ACQUI SI TI ON	0)		111.00
	DO INTEREST EXPENSE	1				-	113.00
	DO UTILIZATION REVIEW-SNF						114.00
115.00 1150	DO AMBULATORY SURGICAL CENTER (D. P.)	0		C		0	115.00
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FLOYD MEMORIAL HOSPITAL & HEALTH SVS In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/27/2016 2:5	
		Tit	le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	npy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
116. 00 11600 HOSPI CE	0			0	0	116.00
200.00Subtotal (see instructions)201.00Less Observation Beds202.00Total (see instructions)	215, 563, 829 7, 292, 576 208, 271, 253	0 0	215, 563, 82 7, 292, 57 208, 271, 25	6	215, 604, 242 7, 292, 576 208, 311, 666	201.00

CONTUNATION OF RATIG OF COSTS TO CHARGES Provider Colt. 190244 Provider Colt.	Health Financial Systems	FLOYD MEMORIAL HOSP	ITAL & HEALTH	SVS	In Lie	u of Form CMS-	2552-10	
Intervent Intervent <th colsp<="" td=""><td></td><td></td><td>Provi der</td><td>F</td><td>Period: From 01/01/2015</td><td>Worksheet C</td><td></td></th>	<td></td> <td></td> <td>Provi der</td> <td>F</td> <td>Period: From 01/01/2015</td> <td>Worksheet C</td> <td></td>			Provi der	F	Period: From 01/01/2015	Worksheet C	
Cost Center Description Inpatient But patient Form (Cost or Cher) Cost or Cher) Cost or Cher (Cost or Cher) Cost o				le XIX	Hospi tal	Cost		
IMANT LET. BUT THE SERVICE COST CENTERS 40, 873, 417 40, 830, 00 43, 00 43, 00 43, 00 43, 00 43, 00 43, 00 40, 00 41, 00 40, 00 41, 00 40, 00 41, 00 40, 00 41, 0	Cost Center Description	I npati ent	<u>J</u>			Inpatient		
30.00 40.00 40.00 <td< td=""><td></td><td>6.00</td><td>7.00</td><td>8.00</td><td>9.00</td><td>10.00</td><td></td></td<>		6.00	7.00	8.00	9.00	10.00		
31.00 DISTOL INTERSINE CARE UNIT 7, 445, 882 7, 445, 882 7, 445, 882 31.00 32.00 DISTOL INTERSINE CARE UNIT 8 9 30.00 32.00 DISTOL INTERSINE CARE UNIT 8 9 30.00 40.00 40.		10 972 117		40 972 41	7		20.00	
32.00 DOROMARY CARE UNIT 0 0 32.00 DOROMARY CARE UNIT 0 33.00 30.00 33.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
31.00 03:00 03:00 03:00 03:00 04:00 00:00:00 0:00:00:00 0:00:000 0:00:00:0		0		(5			
40.00 DATOD SUBPRIVIDER - IFF 0<		0		(D			
1.00 O HONO SUBPRIVIDER - I RF 0 0 41.00 40.00 DATOS SUBPRIVIDER - I RF 0 0 42.00 42.00 43.00 DATOS SUBPRIVIDER - I RF 2.652.307 2.652.307 2.652.307 43.00 43.00 DATOS SUBPRIVIDER - I RF 2.652.307 2.652.307 0 43.00 44.00 DATOS SUBPRIVIDER - I RF 2.652.307 2.652.307 0		0		(D			
42:00 DURKSEY 2.62.307 2.62.307 2.62.307 4.200		0						
41.00 0 04300 NURSERY 2, 652, 367 4, 50 43.00 44.00 45.00 0 64400 NURSING FACLUTY 0 0 0 44.00 45.00 0 64000 NURSING FACLUTY 0		-						
44.00 0 0 0 0 44.00 0 45.00		-						
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99.10 09910 CORF 0 0 0 99.10 100.00 1& & SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 5, 619, 278 5, 619, 278 5, 619, 278 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUI SI TI ON 0 0 105.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 107.00 107.00 106.00 106.00 106.00 107.00 107.00 107.00 107.00 107.00 107.00 106.00 107.00 107.00 107.00 107.00 107.00 107.00 106.00 107.00 106.00 107.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 110.00 111.00 111.00 111.00 </td <td></td> <td>0</td> <td>C</td> <td></td> <td>0. 000000</td> <td></td> <td></td>		0	C		0. 000000			
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101.00 10100 HOME HEALTH AGENCY 0 5, 619, 278 5, 619, 278 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105.00 106.00 10600 HEART ACQUI SI TI ON 0 0 0 106.00 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 106.00 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 107.00 107.00 107.00 107.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 111.00 111.00 111.00 111.		0	0		0			
SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUI SITION 0 0 0 105.00 106.00 10600 HEART ACQUI SITION 0 0 0 106.00 107.00 10700 LIVER ACQUI SITION 0 0 0 106.00 107.00 10700 LIVER ACQUI SITION 0 0 0 107.00 108.00 10800 LUNG ACQUI SITION 0 0 0 107.00 109.00 PANCREAS ACQUI SITION 0 0 0 108.00 109.00 PANCREAS ACQUI SITION 0 0 0 109.00 110.00 I1000 INTERSTINAL ACQUI SITION 0 0 110.00 111.00 ISLET ACQUI SITION 0 0 0 111.00 113.00 INTEREST EXPENSE 111.00 111.00 111.00 111.00 113.00 114.00 114.00 115.00 115.00 115.00 115.00 115.00 116.00 0 <t< td=""><td></td><td></td><td>5 610 279</td><td>5 610 270</td><td></td><td></td><td></td></t<>			5 610 279	5 610 270				
105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105.00 106.00 10600 HEART ACQUI SI TI ON 0 0 0 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 107.00 108.00 LUNG ACQUI SI TI ON 0 0 0 0 108.00 109.00 PANCREAS ACQUI SI TI ON 0 0 0 108.00 109.00 PANCREAS ACQUI SI TI ON 0 0 0 109.00 100.01 INTESTI NAL ACQUI SI TI ON 0 0 0 110.00 110.00 INTESTI NAL ACQUI SI TI ON 0 0 0 111.00 111.00 INTON 0 0 0 111.00 111.00 113.00 INTEREST EXPENSE 113.00 113.00 113.00 114.00 114.00 114.00 115.00 115.00 115.00 115.00 116.00 0 0 0 116.00 <td></td> <td>0</td> <td>5, 019, 270</td> <td>J 3, 017, 270</td> <td></td> <td></td> <td>101.00</td>		0	5, 019, 270	J 3, 017, 270			101.00	
106.00 10600 HEART ACQUI SI TI ON 0 0 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 107.00 108.00 10800 LUNG ACQUI SI TI ON 0 0 0 107.00 108.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 108.00 109.00 PANCREAS ACQUI SI TI ON 0 0 0 109.00 110.00 INTESTI NAL ACQUI SI TI ON 0 0 0 1109.00 111.00 INTEST EXPENSE 0 0 0 111.00 113.00 INTEREST EXPENSE 113.00 113.00 114.00 114.00 114.00 115.00 115.00 115.00 115.00 115.00 116.00 0 0 0 116.00		0	C) ()		105.00	
108.00 LUNG ACQUI SI TI ON 0 0 0 108.00 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 109.00 110.00 INTESTI NAL ACQUI SI TI ON 0 0 0 110.00 109.00 111.00 INTESTI NAL ACQUI SI TI ON 0 0 0 110.00 110.00 111.00 ISLET ACQUI SI TI ON 0 0 0 0 111.00 113.00 INTEREST EXPENSE 0 0 0 113.00 113.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 115.00 115.00 115.00 0 0 0 115.00 115.00 116.00 105.00 116.00 116.00 0 0 116.00 0 116.00 116.00 0 0 116.00 0 0 116.00 0 0 0 116.00 0 0 0 116.00 116.00 116.00 116.00 116.00 0 0 116.00 0 0 0 0 116.00 </td <td></td> <td>0</td> <td>C</td> <td>) (</td> <td>D</td> <td></td> <td></td>		0	C) (D			
109.00 PANCREAS ACQUI SI TI ON 0 0 0 109.00 110.00 INTESTI NAL ACQUI SI TI ON 0 0 0 110.00 111.00 INTESTI NAL ACQUI SI TI ON 0 0 0 110.00 111.00 ISLET ACQUI SI TI ON 0 0 0 111.00 113.00 INTEREST EXPENSE 113.00 111.00 113.00 114.00 111 IZATI ON REVIEW-SNF 114.00 114.00 115.00 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 115.00 116.00 11600 HOSPI CE 0 0 0 116.00		0	C					
110.00 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 ISLET ACQUISITION 0 0 0 111.00 113.00 INTEREST EXPENSE 113.00 111.00 111.00 111.00 114.00 ITILIZATION REVIEW-SNF 114.00 115.00 115.00 115.00 0 0 0 116.00 11600 HOSPICE 0 0 0 116.00		0	0					
111.00 1 SLET ACQUI SI TI ON 0 0 0 111.00 113.00 1 NTEREST EXPENSE 113.00 113.00 114.00 111.00 113.00 114.00 114.00 UTI LI ZATI ON REVI EW-SNF 114.00 114.00 115.00 115.00 115.00 115.00 115.00 115.00 115.00 116.00 0 0 116.00 <t< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></t<>		0						
113.00 INTEREST EXPENSE 113.00 114.00 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 116.00 11600 HOSPI CE 0 0 116.00		0	((
115.00 11500 AMBULATORY SURGI CAL CENTER 0 0 0 115.00 116.00 11600 HOSPI CE 0 0 0 116.00	113.00 11300 INTEREST EXPENSE							
116. 00 11600 HOSPI CE 0 116. 00 11600 HOSPI CE								
		0		ין (וי		1110.00	

Health Fin	ancial Systems	LOYD MEMORIAL HOSI	PITAL & HEALT	H SVS	In Lie	u of Form CMS	-2552-10
COMPUTATIC	N OF RATIO OF COSTS TO CHARGES		Provi de	r CCN: 150044	Peri od:	Worksheet C	
					From 01/01/2015		
					To 12/31/2015		epared:
						5/27/2016 2:	52 pm
			T	tle XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
200.00	Subtotal (see instructions)	398, 326, 299	505, 325, 2	36 903, 651, 5	85		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	398, 326, 299	505, 325, 2	36 903, 651, 5	85		202.00

Health Financial Systems	FLOYD MEMORIAL HOSPITA	AL & HEALTH SVS	In Lieu	of Form CMS-2552-
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 150044	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared
		Title XIX	Hospi tal	5/27/2016 2:52 pm Cost
Cost Center Description	PPS Inpatient Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTER				
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF INTENSIVE CARE UNIT				30. 0 31. 0 32. 0 33. 0 34. 0 40. 0
41.00 04100 SUBPROVIDER - IRF 42.00 04200 SUBPROVIDER 43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY				41.0 42.0 43.0 44.0
45.00 04500 NURSING FACILITY 46.00 04600 OTHER LONG TERM CARE				45.0
ANCI LLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.0
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000 0. 000000			51.0
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.0
56. 00 05600 RADI OI SOTOPE 57. 00 05700 CT SCAN	0.000000			56.0
58. 00 05800 MRI	0. 000000			58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.0
60. 00 06000 LABORATORY	0. 000000			60.0
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM	0. 000000 0. 000000			60.0 61.0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	0. 000000			62.0
63.00 06300 BLOOD STORING PROCESSING & TRA	0. 000000			63.0
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0.000000			64.0
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0.000000			65.0 66.0
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.0
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.0
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0.000000			69.0 70.0
70. 01 07001 SLEEP DI SORDER	0. 000000			70.0
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PAT	0. 000000			71.0
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000			72.0
74. 00 07400 RENAL DI ALYSI S	0. 000000			73.0
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75.0
76. 00 03950 NUTRI TI ON/DI ABETES	0. 000000			76.0
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0. 000000			76. 9
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88.0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTI				89.0
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	0. 000000 0. 000000			90.0 91.0
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000			91.0
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DI ALYSI S	0.000000			94.0
95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000			95.0 96.0
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97.0
99.00 09900 CMHC				99.0
99. 10 09910 CORF 100. 00 10000 I & SERVICES-NOT APPRVD PRGM				99. 1 100. 0
101. 00 10000 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS				101. 0
105.00 10500 KI DNEY ACQUI SI TI ON				105.0
106.00 10600 HEART ACQUI SI TI ON				106.0
107.00 10700 LIVER ACQUISITION 108.00 10800 LUNG ACQUISITION				107.0 108.0
109. 00 10900 PANCREAS ACQUI SI TI ON				109.0
110.00 11000 INTESTINAL ACQUISITION				110. 0
111.00 11100 I SLET ACQUI SI TI ON				111.0
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF				113. 0 114. 0
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)			115.0
116.00 11600 HOSPI CE				116.0
200.00Subtotal (see instructions)201.00Less Observation Beds				200. 0 201. 0
5/27/2016 2:52 pm C: \MCREE32\ELovd2015 mcrx				μ201. U

Health Financial Systems	FLOYD MEMORIAL HOSPI	TAL & HEALTH SVS	In Lieu	u of Form CMS-2552-	2-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150044	Period: From 01/01/2015	Worksheet C	
				Date/Time Prepare 5/27/2016 2:52 pm	
		Title XIX	Hospi tal	Cost	<u></u>
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
202.00 Total (see instructions)				202.	. 00

Health Financial Systems FLOYE	MEMORIAL HOSP	ITAL & HEALTH	SVS	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der	CCN: 150044	Period: From 01/01/2015 To 12/31/2015		pared:
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cos	t	col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	6, 358, 154	0			106. 41	
31. 00 I NTENSI VE CARE UNI T	481, 396		481, 39	96 4, 800	100. 29	
32.00 CORONARY CARE UNI T	0			0 0	0.00	•
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	
40. 00 SUBPROVIDER - IPF	0	0		0 0	0.00	
41.00 SUBPROVIDER - IRF	0	0		0 0	0.00	•
42.00 SUBPROVI DER	0	0		0 0	0.00	•
43.00 NURSERY	129, 703		129, 70	2, 757	47.04	
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	
45.00 NURSING FACILITY	0			0 0	0.00	45.00
200.00 Total (lines 30-199)	6, 969, 253		6, 969, 2	53 67, 310		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
	(00	col . 6)	-			
INDATIENT POUTINE CEDVICE COST CENTERS	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	24 512	0.001.140	1			1 20 00
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT	26, 512 2, 494	2, 821, 142				30.00 31.00
		250, 123	1			
32.00 CORONARY CARE UNIT	0	0				32.00 33.00
33.00 BURN INTENSIVE CARE UNIT	0	0				33.00
34. 00 SURGI CAL I NTENSI VE CARE UNI T 40. 00 SUBPROVI DER – I PF	0	0				40.00
40. 00 SUBPROVIDER - IPF 41. 00 SUBPROVIDER - IRF	0	0				40.00
41.00 SUBPROVIDER - TRF 42.00 SUBPROVIDER	0	0				41.00
42. 00 SUBPROVIDER 43. 00 NURSERY	0	0				42.00
43.00 NURSERY 44.00 SKILLED NURSING FACILITY	0	0				43.00
45.00 NURSING FACILITY	0	0				44.00
200.00 Total (lines 30-199)	29,006	0				200.00
200. 00 10 tai (111105 30-177)	27,000	3, 071, 203	1			l≥00.00

PORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L 00313	Provider	CCN: 150044	Period: From 01/01/2015 To 12/31/2015		pared: 2 pm
		Ti tl	e XVIII	Hospi tal	PPS	•
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)	5		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	11 00	2100	0100		0100	
0. 00 05000 OPERATING ROOM	1, 847, 475	133, 318, 228	0. 01385	8 34, 148, 082	473, 224	50.00
. 00 05100 RECOVERY ROOM	0	0	0.00000		0	1
2. 00 05200 DELIVERY ROOM & LABOR ROOM	785, 466	6, 135, 922			90, 526	
3. 00 05300 ANESTHESI OLOGY	703, 400	0, 100, 722	0. 00000		,0,320	
I. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 573, 547	74, 619, 823			-	
	1, 575, 547	14,019,023				
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000		0	
0. 00 05600 RADI OI SOTOPE	0	0	0.00000		0	
7. 00 05700 CT SCAN	283, 357	46, 804, 279			55, 078	
3. 00 05800 MRI	238, 319	27,001,073	0. 00882			
2. 00 05900 CARDI AC CATHETERI ZATI ON	644, 296	83, 703, 082			143, 350	
0. 00 06000 LABORATORY	765, 786	99, 898, 221	0. 00766	6 24, 758, 176	189, 796	60.00
0. 01 06001 BLOOD LABORATORY	0	0	0. 00000	0 0	0	60. 0 ⁻
. 00 06100 PBP CLINICAL LAB SERVICES-PRGM					1	61.00
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD	0	0	0. 00000	0 0	0	62.00
3. 00 06300 BLOOD STORING PROCESSING & TRA	0	0	0.00000		0	63.00
I. 00 06400 I NTRAVENOUS THERAPY	10, 338	3, 278, 384	0.00315			
5. 00 06500 RESPIRATORY THERAPY	159, 904	21, 395, 298				
5. 00 06600 PHYSI CAL THERAPY	128, 517	24, 816, 516			16, 116	
7. 00 06700 OCCUPATI ONAL THERAPY	120, 017	21,010,010	0.00000		0	
3. 00 06800 SPEECH PATHOLOGY	21, 074	1, 078, 997	0. 01953			
2. 00 06900 ELECTROCARDI OLOGY	368, 930	54, 474, 095			68, 802	
0. 00 07000 ELECTROENCEPHALOGRAPHY	198, 719	904, 243	0. 21976		14, 720	
0. 01 07001 SLEEP DI SORDER	147, 317	9, 654, 022	0.01526		284	
. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT	418, 342	24, 140, 929			113, 275	
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	563, 633	20, 716, 379			189, 392	
8.00 07300 DRUGS CHARGED TO PATIENTS	579, 118	137, 158, 603			107, 628	
I. 00 07400 RENAL DI ALYSI S	0	0	0. 00000		0	
5.00 07500 ASC (NON-DISTINCT PART)	0	0	0. 00000		0	
5. 00 03950 NUTRI TI ON/DI ABETES	0	0	0.00000		0	76.00
5. 97 07697 CARDI AC REHABI LI TATI ON	133, 826	1, 493, 775	0. 08958	9 1, 590	142	76.9
OUTPATIENT SERVICE COST CENTERS			_			
3. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88.00
2.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	0 0	0	89.00
0. 00 09000 CLINIC	180, 527	6, 157, 399	0. 02931	9 464, 825	13, 628	90.00
. 00 09100 EMERGENCY	1,005,842	52, 192, 479	0. 01927	7, 310, 192	140, 882	91.00
2.00 09200 OBSERVATION BEDS (NON-DISTINCT	959, 900	9, 118, 914		5 893, 408	94, 045	92.00
OTHER REIMBURSABLE COST CENTERS						1
I. OO O9400 HOME PROGRAM DI ALYSI S	0	0	0.00000	0 0	0	94.00
5. 00 09500 AMBULANCE SERVICES	Ű	0			, j	95.00
5. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	0 0	0	
- 55 57550 DURADEL MEDIONE EQUIT TRENTED	0	0			-	
7.00 09700 DURABLE MEDICAL EQUIP-SOLD		∩	0.00000		0	97.0

Health Financial Systems FLOYI	D MEMORIAL HOSP		21/2	Inlie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P		TS Provi der	CCN: 150044	Peri od: From 01/01/2015 To 12/31/2015 Hospi tal	Worksheet D Part III	pared:
		Titl	Title XVIII		PPS	
Cost Center Description	Nursi ng	Allied Health	All Other	Swing-Bed	Total Costs	
	School	Cost	Medi cal	Adjustment	(sum of cols.	
			Education	Amount (see	1 through 3,	
			Cost		minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
32.00 03200 CORONARY CARE UNI T	0	0		0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	0	34.00
40. 00 04000 SUBPROVI DER – I PF	0	0		0 0	0	40.00
41. 00 04100 SUBPROVI DER – I RF	0	0		0 0	0	41.00
42. 00 04200 SUBPROVI DER	0	0		0 0	0	42.00
43. 00 04300 NURSERY	0	0		0	0	43.00
44. 00 04400 SKILLED NURSING FACILITY	0	0		0	0	
45. 00 04500 NURSI NG FACI LI TY	0	0		0	0	
200.00 Total (lines 30-199)	0	0		0	-	200.00
Cost Center Description	Total Patient	Per Diem	Inpati ent	Inpatient	0	200.00
cost center bescription	Days	(col. 5 ÷	Program Days			
	Days	col. 6)		Pass-Through		
		COI. 0)		Cost (col. 7		
				x col. 8)		
	6.00	7.00	8,00	9,00		
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00		
30. 00 03000 ADULTS & PEDIATRICS	59, 753	0.00	26, 51	2 0		30.00
31.00 03100 I NTENSI VE CARE UNI T	4, 800	0.00	2, 49	04 0		31.00
32.00 03200 CORONARY CARE UNI T	0	0.00		0 0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0.00		0 0		33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0.00		0 0		34.00
40. 00 04000 SUBPROVI DER – I PF	0	0.00		0 0		40.00
41. 00 04100 SUBPROVI DER – I RF	0	0.00		0 0		41.00
42. 00 04200 SUBPROVI DER	0	0.00		0 0		42.00
43. 00 04300 NURSERY	2,757	0.00				43.00
44. 00 04400 SKILLED NURSING FACILITY	2,737	0.00				44.00
45. 00 04400 SKIELED NORSING FACILITY	0	0.00				45.00
200.00 Total (lines 30-199)	67, 310		29,00			200.00
200.00 [TOTAL (THES 30-177)	07,310	l	27,00	0	I	200.00

	Financial Systems FLC FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	OYD MEMORIAL HOSPI		CCN: 150044	Period:	eu of Form CMS- Worksheet D	2002-10
	GH COSTS		11 ovr der		From 01/01/2015	Part IV	
					To 12/31/2015		
				e XVIII	Hospi tal	5/27/2016 2:5 PPS	oz pili
	Cost Center Description	Non Physi ci an	Nursing	Allied Heal		Total Cost	
		Anesthetist	School		Medi cal	(sum of col 1	
		Cost			Educati on	through col.	
					Cost	4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS					1	_
50.00	05000 OPERATING ROOM	0	C		0 0		
51.00	05100 RECOVERY ROOM	0	C		0 0		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0		
53.00	05300 ANESTHESI OLOGY	0	C)	0 0	-	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 (-	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C)	0 (-	
56.00	05600 RADI OI SOTOPE	0	C		0 0		
57.00	05700 CT SCAN	0	C		0 0		
58.00	05800 MRI	0	C		0 0		
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C)	0 0		
60.00	06000 LABORATORY	0	C		0 0		
60.01	06001 BLOOD LABORATORY	0	C)	0 0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	0	C		0 0		
63.00	06300 BLOOD STORING PROCESSING & TRA	0	C		0 0		
64.00	06400 I NTRAVENOUS THERAPY	0	C		0 0		64.00
65.00		0	C		0 0		
66.00	06600 PHYSI CAL THERAPY	0	Ĺ		0 0	°	
67.00	06700 OCCUPATI ONAL THERAPY	0	C		0 0		
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0					
70.00	07000 ELECTROEARDTOLOGT	0	0		0 0	°	
70.00	07000 ELECTROENCEPHALOGRAPHY	0					
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0					
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	-	
73.00	07300 DRUGS CHARGED TO PATIENTS	0			0 0		
74.00	07400 RENAL DI ALYSI S	0			0 0	° °	
75.00	07500 ASC (NON-DISTINCT PART)	0	C		0 0	° °	
76.00	03950 NUTRI TI ON/DI ABETES	0	C		0 0		
76.97	07697 CARDI AC REHABI LI TATI ON	0	C		0 0		
/0///	OUTPATIENT SERVICE COST CENTERS				<u> </u>	·1	1
88.00	08800 RURAL HEALTH CLINIC	0	C		0 0	0 0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0	0	89.00
90.00	09000 CLI NI C	0	C		0 0	0	90.00
91.00	09100 EMERGENCY	0	C		0 0		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	C		0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DI ALYSI S	0	C)	0 0	0 0	94.00
95.00	09500 AMBULANCE SERVI CES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0 0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0 0		97.00
			C				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY		S Provi der	CCN: 150044	Peri od:	u of Form CMS-: Worksheet D	
THROUGH COSTS				From 01/01/2015 To 12/31/2015	Part IV Date/Time Pre	pared:
		Ti +I	e XVIII	Hospi tal	5/27/2016 2:5 PPS	p2 pm
Cost Center Description	Total	Total Charges			Inpatient	
cost center bescription	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col . 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷	ondi ges	
	4)			col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	133, 318, 228	0.0000	0. 000000	34, 148, 082	50.00
51.00 05100 RECOVERY ROOM	0	0	0.00000	0. 000000	0	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	6, 135, 922	0.0000	0. 000000	707, 177	52.0
53. 00 05300 ANESTHESI OLOGY	0	0	0. 00000	0. 000000	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	74, 619, 823	0. 00000	0. 000000	8, 321, 765	54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000	0. 000000	0	55.0
56. 00 05600 RADI 0I SOTOPE	0	0	0.00000	0. 000000	0	56.0
7. 00 05700 CT SCAN	0	46, 804, 279	0. 00000	0. 000000	9, 097, 842	57.0
58. 00 05800 MRI	0			0. 000000	3, 708, 816	
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	83, 703, 082	0.00000	0. 000000	18, 624, 171	59.0
0. 00 06000 LABORATORY	0				24, 758, 176	
0.01 06001 BLOOD LABORATORY	0				0	
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM	-				-	61.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD	0	0	0. 00000	0. 000000	0	
3. 00 06300 BLOOD STORING PROCESSING & TRA	0	-			0	
54. 00 06400 I NTRAVENOUS THERAPY	0				49, 209	
55. 00 06500 RESPIRATORY THERAPY	0				11, 162, 478	
6. 00 06600 PHYSI CAL THERAPY	0		1		3, 111, 732	
57. 00 06700 OCCUPATI ONAL THERAPY	0	24,010,010	1		3, 111, 732	67.0
58. 00 06800 SPEECH PATHOLOGY	0	-			546, 162	
9.00 06900 ELECTROCARDI OLOGY	0				10, 158, 333	
0.00 07000 ELECTROENCEPHALOGRAPHY	0				66, 981	
0. 01 07001 SLEEP DI SORDER	0				18, 623	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0				6, 536, 734	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				6, 961, 142	
73. 00 07200 DRUGS CHARGED TO PATIENTS	0				25, 492, 251	
4.00 07400 RENAL DIALYSIS	0	,,			23, 492, 231	
5. 00 07500 ASC (NON-DI STINCT PART)	0		1		0	
6. 00 03950 NUTRI TI ON/DI ABETES	0		1		0	
6. 97 07697 CARDIAC REHABILITATION	0	-			1, 590	
OUTPATIENT SERVICE COST CENTERS	0	1,493,773	0.0000	0.00000	1, 390	/0.9
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0. 000000	0	88.0
39. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-			0	
0.00 09000 FEDERALLY QUALIFIED HEALTH CENTER	0				464, 825	
21. 00 09100 EMERGENCY	-					
22.00 09200 OBSERVATION BEDS (NON-DISTINCT	0				7, 310, 192 893, 408	
OTHER REIMBURSABLE COST CENTERS	0	9, 110, 914	1 0.0000		073, 408	92.0
04.00 09400 HOME PROGRAM DIALYSIS	0	0	0.00000	0. 000000	0	94.0
			0.0000	0.00000	0	
	_	0	0.0000		0	95.0
26. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0				-	
77.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	-		0. 000000	172 120 (00	
200.00 Total (lines 50-199)	0	838, 060, 661	I		172, 139, 689	1200.0

	Financial Systems FL0 TONMENT OF INPATIENT/OUTPATIENT ANCILLARY S			CCN: 150044	Peri od:	Worksheet D	-2552-10
	H COSTS	ENTITE OTHER TAS		0011. 100044	From 01/01/2015	5 Part IV	
					To 12/31/2015	5 Date/Time Pr 5/27/2016 2:	
			Ti †I	e XVIII	Hospi tal	PPS	52 pili
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	·	Program	Program	Program			
		Pass-Through	Charges	Pass-Throug			
		Costs (col. 8		Costs (col.			
		x col. 10)	12.00	x col. 12)	1		
	ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00			
50.00	05000 OPERATING ROOM	0	19, 812, 678		0		50.00
51.00	05100 RECOVERY ROOM	0	(),012,070		0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	121, 371		0		52.00
53.00	05300 ANESTHESI OLOGY	0	C		0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	19, 997, 737	,	0		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C)	0		55.00
56.00	05600 RADI OI SOTOPE	0	C		0		56.00
57.00	05700 CT SCAN	0	8, 465, 873		0		57.00
58.00	05800 MRI	0	6, 183, 929		0		58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	26, 111, 715		0		59.00
50.00		0	9, 041, 683		0		60.00
50.01 51.00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM	0	C	1	0		60.01
51.00	06200 WHOLE BLOOD & PACKED RED BLOOD	0	C		0		62.00
52.00 53.00	06300 BLOOD STORING PROCESSING & TRA	0			0		63.00
54.00	06400 I NTRAVENOUS THERAPY	0	1, 436, 819		0		64.00
55.00	06500 RESPI RATORY THERAPY	0	1,077,123		0		65.00
56.00	06600 PHYSI CAL THERAPY	0	1, 890		0		66.00
57.00	06700 OCCUPATI ONAL THERAPY	0	C		0		67.00
58.00	06800 SPEECH PATHOLOGY	0	998		0		68.00
59.00	06900 ELECTROCARDI OLOGY	0	6, 008, 388	6	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	200, 610		0		70.00
70. 01	07001 SLEEP DI SORDER	0	2, 873, 735		0		70.01
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PAT	0	3, 211, 393		0		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	3, 180, 937		0		72.00
73.00	07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S	0	36, 138, 867 C		0		73.00
75.00	07500 ASC (NON-DI STINCT PART)	0			0		75.00
76.00	03950 NUTRI TI ON/DI ABETES	0			0		76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	811, 672		0		76.97
	OUTPATIENT SERVICE COST CENTERS	-		1	-1		
38.00	08800 RURAL HEALTH CLINIC	0	C)	0		88. 00
39.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0		89.00
90.00	09000 CLI NI C	0	2, 103, 328		0		90.00
91.00	09100 EMERGENCY	0	7, 599, 703		0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	2, 316, 178		0		92.00
A 00	OTHER REIMBURSABLE COST CENTERS			J	0		
	09400 HOME PROGRAM DI ALYSI S	0	C		0		94.00
95.00	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0		95.00
96.00 97.00	09700 DURABLE MEDICAL EQUIP-RENTED	0			0 0		96.00 97.00
							1 77.00

APPORTIONMENT OF ME	stems FLOY DICAL, OTHER HEALTH SERVICES AN		ITAL & HEALTH Provider	CCN: 150044	Peri od:	Worksheet D	2552-10
					From 01/01/2015 To 12/31/2015	Part V Date/Time Pre	
			T: +1	o XV/111	llooni tol	5/27/2016 2:5	52 pm
			11 (1	e XVIII Charges	Hospi tal	Costs	
Cost Ce	nter Description	Cost to	PPS	Cost	Cost	PPS Services	
0031 00		Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Services (see		Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins	. Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	RVICE COST CENTERS	0 11/15/	19, 812, 678	1	0 0	2 201 222	50.00
		0. 116154				2, 301, 322	1
	Y ROOM & LABOR ROOM	0. 000000 0. 560927	0 121, 371		0 0	0 68, 080	1
53.00 05300 ANESTHE		0. 000000	121, 3/1		0 0	08, 080	1
	GY-DI AGNOSTI C	0. 225842	19, 997, 737		0 0	4, 516, 329	
	GY-THERAPEUTI C	0. 000000			0 0	4, 510, 527	
56.00 05600 RADIOIS		0. 000000	0		0 0	0	1
57.00 05700 CT SCAN		0. 034964	8, 465, 873		0 0	296, 001	57.00
58.00 05800 MRI		0.036592	6, 183, 929		0 0	226, 282	
59.00 05900 CARDI AC	CATHETERI ZATI ON	0. 048504	26, 111, 715		0 0	1, 266, 523	
60.00 06000 LABORAT	ORY	0. 131267	9, 041, 683	39, 60	06 0	1, 186, 875	60.00
60.01 06001 BLOOD L		0. 000000	0		0 0	0	60.01
61.00 06100 PBP CLI	NICAL LAB SERVICES-PRGM	0. 000000			0 0		61.00
	LOOD & PACKED RED BLOOD	0. 000000	0		0 0	0	
	TORING PROCESSING & TRA	0. 000000	0		0 0	0	
64.00 06400 I NTRAVE		0. 211034	1, 436, 819		0 0	303, 218	
65.00 06500 RESPI RA		0. 150481	1,077,123		0 0	162, 087	
66.00 06600 PHYSI CA		0. 212414	1, 890		0 0	401	66.00
	I ONAL THERAPY	0. 000000	0		0 0	0	
68.00 06800 SPEECH 69.00 06900 ELECTRO		0. 319725 0. 078947	998 6, 008, 388		0 0	319 474, 344	1
	ENCEPHALOGRAPHY	0. 545199			0 0	109, 372	
70.01 07001 SLEEP D		0. 138326	2, 873, 735		0 0	397, 512	
	SUPPLIES CHARGED TO PAT	0. 637169	3, 211, 393		0 0	2,046,200	
	EV. CHARGED TO PATIENTS	1. 000363	3, 180, 937		0 0	3, 182, 092	
	HARGED TO PATIENTS	0. 228482	36, 138, 867		0 164, 289	8, 257, 081	
74.00 07400 RENAL D		0. 000000	0		0 0	0	1
75.00 07500 ASC (NO	N-DISTINCT PART)	0. 000000	0		0 0	0	75.00
76.00 03950 NUTRI TI	ON/DI ABETES	0. 000000	0		0 0	0	76.00
	REHABI LI TATI ON	0. 530968	811, 672		0 0	430, 972	76.97
	RVICE COST CENTERS			1			
88.00 08800 RURAL H		0. 000000				0	1
	LY QUALIFIED HEALTH CENTER	0.000000				0	
90.00 09000 CLINIC 91.00 09100 EMERGEN	CV.	0. 269197	2, 103, 328		0 0	566, 210	
	TION BEDS (NON-DISTINCT	0. 152697	7, 599, 703		0 0	1, 160, 452	
	RSABLE COST CENTERS	0. 799720	2, 316, 178		0 0	1, 852, 294	92.00
	OGRAM DIALYSIS	0.000000			0		94.00
95.00 09500 AMBULAN		0. 000000			0		95.00
	MEDICAL EQUIP-RENTED	0. 000000			0 0	0	
	MEDICAL EQUIP-SOLD	0. 000000			0 0	0	1
1 1	I (see instructions)	1	156, 696, 627	39, 60	164, 289	28, 803, 966	
	P Clinic Lab. Services-Program				0 0		201.00
201.00 1203310					1		1
Only Ch	arges rges (line 200 +/- line 201)		156, 696, 627				

Health Financial Systems	FLOY	D MEMORIAL HOSP	ITAL & HEALTH	SVS	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTH	HER HEALTH SERVICES AND	D VACCINE COST	Provi der	CCN: 150044	Period: From 01/01/2015 To 12/31/2015		
			Ti t	e XVIII	Hospi tal	PPS	<u>52 pili</u>
		Cos			nospital	115	
Cost Center Desc	ription	Cost	Cost	-			
	L · · ·	Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)	_			
		6.00	7.00				
ANCI LLARY SERVICE COST	CENTERS						
50.00 05000 OPERATING ROOM		0					50.00
51.00 05100 RECOVERY ROOM		0					51.00
52.00 05200 DELIVERY ROOM & I	_ABOR ROOM	0					52.00
53.00 05300 ANESTHESI OLOGY	STLO	0					53.00
54.00 05400 RADI OLOGY-DI AGNO		0					54.00
55. 00 05500 RADI OLOGY-THERAPI 56. 00 05600 RADI OI SOTOPE		0					55.00 56.00
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN		0					57.00
58. 00 05800 MRI		0					58.00
59. 00 05900 CARDI AC CATHETER		0					59.00
60. 00 06000 LABORATORY	2411 010	5, 199					60.00
60. 01 06001 BLOOD LABORATORY		0					60.00
61. 00 06100 PBP CLINICAL LAB	SERVI CES-PRGM	0					61.00
62.00 06200 WHOLE BLOOD & PAG		0		b			62.00
63.00 06300 BLOOD STORING PI		0					63.00
64.00 06400 INTRAVENOUS THER		0	(S			64.00
65.00 06500 RESPI RATORY THER		0	(b			65.00
66.00 06600 PHYSI CAL THERAPY		0	(b			66.00
67.00 06700 OCCUPATI ONAL THEI	RAPY	0	(b			67.00
68.00 06800 SPEECH PATHOLOGY		0	(C			68.00
69.00 06900 ELECTROCARDI OLOG	ſ	0	(C			69.00
70.00 07000 ELECTROENCEPHALO	GRAPHY	0		D			70.00
70.01 07001 SLEEP DI SORDER		0		2			70.01
71.00 07100 MEDICAL SUPPLIES		0		C			71.00
72.00 07200 I MPL. DEV. CHARGI		0					72.00
73.00 07300 DRUGS CHARGED TO	PATTENTS	0	37, 53	1			73.00
74.00 07400 RENAL DI ALYSI S		0					74.00
75.00 07500 ASC (NON-DI STI NC		0		D			75.00
76. 00 03950 NUTRI TI ON/DI ABETI		0					76.00
76. 97 07697 CARDI AC REHABI LI OUTPATI ENT SERVI CE COS		0		0			76.97
88.00 08800 RURAL HEALTH CLII		0		D			88.00
89.00 08900 FEDERALLY QUALIFI		0					89.00
90. 00 09000 CLINIC	ED HEALTH CENTER	0					90.00
91.00 09100 EMERGENCY		0					91.00
92.00 09200 OBSERVATION BEDS	(NON-DI STI NCT	0					92.00
OTHER REIMBURSABLE COS			<u> </u>	<u></u>			72.00
94.00 09400 HOME PROGRAM DI AI		0		D			94.00
95.00 09500 AMBULANCE SERVICI		0		-			95.00
96.00 09600 DURABLE MEDICAL I		0		c			96.00
97.00 09700 DURABLE MEDICAL I		0		D			97.00
200.00 Subtotal (see ins		5, 199	37, 53	7			200.00
201.00 Less PBP Clinic I	_ab. Services-Program	0					201.00
Only Charges	-						
202.00 Net Charges (line	e 200 +/- line 201)	5, 199	37, 53	7			202.00

	MEMORIAL HOSP				u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provi der	CCN: 150044	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pre	nared.
				10 12/31/2013	5/27/2016 2:5	
		Tit	le XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio From	Reimbursed	Reimbursed Services	Reimbursed Services Not	(see inst.)	
	Worksheet C,	Services (see inst.)	Subject To	Subject To		
	Part I, col.	11131.)	Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 116154				0	
51.00 05100 RECOVERY ROOM	0. 000000		1	0 0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 560927	0	_, _,		0	
53. 00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 225842 0. 000000			50 0 0 0	0	
56. 00 05500 RADI 0L0GT-THERAPEUTIC	0. 000000			0 0	0	
57. 00 05700 CT SCAN	0. 034964	0			0	
58. 00 05800 MRI	0. 036592	-			0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 048504	0			0	
60. 00 06000 LABORATORY	0. 131267	0		-	0	
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM	0. 000000			0 0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	0. 000000	0		0 0	0	62.00
63.00 06300 BLOOD STORING PROCESSING & TRA	0. 000000	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 211034	0			0	
65. 00 06500 RESPI RATORY THERAPY	0. 150481	0			0	
66. 00 06600 PHYSI CAL THERAPY	0. 212414				0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0. 319725		,,,,,,		0	
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 078947 0. 545199	0			0	
70. 01 07000 ELECTROENCEPHALOGRAPHY 70. 01 07001 SLEEP DI SORDER	0. 138326				0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 637169			-	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	1. 000363				0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 228482	0			0	
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
76. 00 03950 NUTRI TI ON/DI ABETES	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 530968	0	24, 45	56 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	1	1	1			
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.00000		010.00		0	
90. 00 09000 CLINIC	0. 269197	0			0	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 152697 0. 799720				0	
OTHER REIMBURSABLE COST CENTERS	0. 799720	0	210, 50	0	0	92.00
94.00 09400 HOME PROGRAM DI ALYSI S	0. 000000			0		94.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			0		95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000		1	0 0	0	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			0 0	0	
		1	1 10 010 0-			
200.00 Subtotal (see instructions)		0	12, 348, 87	79 0	0	200.00
200.00Subtotal (see instructions)201.00Less PBP Clinic Lab. Services-Program		0	12, 348, 87	0 0	0	200.00
200.00 Subtotal (see instructions)		0		0 0		

Health Financial Systems FLOYI	D MEMORIAL HOSP	PITAL & HEALTH	SVS	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST		CCN: 150044	Peri od: From 01/01/2015 To 12/31/2015		
			tle XIX	Hospi tal	Cost	
		sts	4			
Cost Center Description	Cost Reimbursed	Cost Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.) 6.00	(see inst.)	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATI NG ROOM	177, 540		0			50.00
51.00 05100 RECOVERY ROOM	0					51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 162					52.00
53. 00 05300 ANESTHESI OLOGY	0					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	380, 557					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0					55.00
56. 00 05600 RADI OI SOTOPE	0	(56.00
57.00 05700 CT SCAN	28, 061					57.00
58. 00 05800 MRI	15,049					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	37, 216					59.00
60. 00 06000 LABORATORY	150, 500	(60.00
60.01 06001 BLOOD LABORATORY	0	(60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM	0					61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	0	(D			62.00
63.00 06300 BLOOD STORING PROCESSING & TRA	0	(63.00
64.00 06400 INTRAVENOUS THERAPY	21, 292		D			64.00
65. 00 06500 RESPI RATORY THERAPY	15, 815		D			65.00
66. 00 06600 PHYSI CAL THERAPY	42, 489		D			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0		D			67.00
68.00 06800 SPEECH PATHOLOGY	3, 097		D			68.00
69.00 06900 ELECTROCARDI OLOGY	36, 712					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	11, 451					70.00
70. 01 07001 SLEEP DI SORDER	40, 056					70.01
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PAT	111, 278					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	192, 049					72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS	571, 635					73.00
74. 00 07400 RENAL DI ALYSI S	0					74.00 75.00
75. 00 07500 ASC (NON-DI STI NCT PART) 76. 00 03950 NUTRI TI ON/DI ABETES	0					76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	12, 985					76.97
OUTPATIENT SERVICE COST CENTERS	12, 903		<u>л</u>			/0. 7/
88.00 08800 RURAL HEALTH CLINIC	0		0			88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0					89.00
90. 00 09000 CLINIC	59, 041					90.00
91. 00 09100 EMERGENCY	226, 985					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	172, 371					92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	(94.00
95. 00 09500 AMBULANCE SERVI CES	0					95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0		o			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0					97.00
200.00 Subtotal (see instructions)	2, 307, 341		o			200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	2, 307, 341	(0			202.00

FLOYD	MEMORI AL	HOSPI TAL	&	HEALTH	SVS	

In Lieu of Form CMS-2552-10

leal th	Financial Systems FLOYD MEMORIAL HOSPIT	AL & HEALTH SVS	In Lie	u of Form CMS-2	2552-1
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150044	Period: From 01/01/2015 To 12/31/2015		
		T: 11 - 20/111		5/27/2016 2:5	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS			50, 750	1 1 0
. 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing	, i i i i i i i i i i i i i i i i i i i		59, 753 59, 753	
. 00	Private room days (excluding swing-bed and observation bed d		rivate room davs	59,755	
. 00	do not complete this line.	ays). If you have only p	ni vate room days,	U	3.0
. 00	Semi-private room days (excluding swing-bed and observation	bed days)		50, 732	4.0
. 00	Total swing-bed SNF type inpatient days (including private r		er 31 of the cost		
	reporting period				
. 00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6.0
00	reporting period (if calendar year, enter 0 on this line)	om davis) through Docombo	r 21 of the cost	0	7.0
. 00	Total swing-bed NF type inpatient days (including private row reporting period	un days) through becembe	er 31 OF the cost	U	7.0
. 00	Total swing-bed NF type inpatient days (including private ro	om davs) after December	31 of the cost	0	8.0
	reporting period (if calendar year, enter 0 on this line)			, S	
9.00	Total inpatient days including private room days applicable	to the Program (excludir	ig swing-bed and	26, 512	9.00
	newborn days)				
0.00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10.0
1.00	through December 31 of the cost reporting period (see instru- Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11.0
1.00	December 31 of the cost reporting period (if calendar year,		Toom days) after	U	11.0
2.00	Swing-bed NF type inpatient days applicable to titles V or X		ite room davs)	0	12.0
	through December 31 of the cost reporting period	3 (3)			
3.00	Swing-bed NF type inpatient days applicable to titles V or X			0	13.0
	after December 31 of the cost reporting period (if calendar				
4.00	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	l days)	0	
5.00	Total nursery days (title V or XIX only)			0	
6.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.0
7.00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	17.0
	reporting period			0.00	
8.00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18.0
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 c	of the cost	0.00	19.0
0 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	os after December 21 of	the cost	0.00	20.0
0.00	reporting period	es arter becember 51 01	the cost	0.00	20.0
1. 00	Total general inpatient routine service cost (see instruction	ns)		48, 304, 319	21.0
2.00	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost repor	ting period (line	0	22.0
	5 x line 17)				
3.00	Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reporti	ng period (line 6	0	23.0
4.00	x line 18) Swing-bed cost applicable to NF type services through Decemb	or 21 of the cost report	ing poriod (line	0	24.0
4.00	7 x line 19)	er 51 of the cost report	ing period (ine	U	24.0
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	ng period (line 8	0	25.0
	x line 20)				
6. 00	Total swing-bed cost (see instructions)			0	
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		48, 304, 319	27.0
8.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	od and obsorvation bod o	(hargos)	0	28.0
9.00	Private room charges (excluding swing-bed charges)	ed and observation bed o	nai ges)	0	
0.00	Semi-private room charges (excluding swing-bed charges)			0	
1.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
2.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.0
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
4.00	Average per diem private room charge differential (line 32 m		ICTI ONS)	0.00	
5.00 6.00	Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35)	ine 31)		0. 00 0	
6.00 7.00	General inpatient routine service cost net of swing-bed cost	and private room cost of	lifferential (line		
	27 minus line 36)	and private room cost c		40, 304, 317	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			
8.00	Adjusted general inpatient routine service cost per diem (se	-		808.40	
9.00	Program general inpatient routine service cost (line 9 x line			21, 432, 301	
	Medically necessary private room cost applicable to the Prog				40.0
1.00	Total Program general inpatient routine service cost (line 3	7 + IIIIE 40)	l	21, 432, 301	41.0

	Financial Systems FLOYD FATION OF INPATIENT OPERATING COST	MEMORIAL HOSP		CCN: 150044	Period:	u of Form CMS- Worksheet D-	
					From 01/01/2015 To 12/31/2015	Date/Time Pre	epare
				e XVIII	Hospi tal	5/27/2016 2: 9 PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient	Inpati ent	Diem (col. 1		(col. 3 x	
		<u>Cost</u> 1.00	Days 2.00	÷ col. 2) 3.00	4.00	<u>col. 4)</u> 5.00	-
. 00	NURSERY (title V & XIX only)	0) 42.
~ ~	Intensive Care Type Inpatient Hospital Units		4 000	1 000			
. 00 . 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	4, 945, 961 0	4,800	1, 030. 4 0. 0		2, 569, 843 C	
. 00	BURN INTENSIVE CARE UNIT	0		0.0			
. 00	SURGICAL INTENSIVE CARE UNIT	0	C			C	
. 00							47.
	Cost Center Description					1.00	
00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			33, 126, 276	6 48.
00	Total Program inpatient costs (sum of lines	41 through 48)	(see instructi	ons)		57, 128, 420) 49.
00	PASS THROUGH COST ADJUSTMENTS	ationt routing	convious (fro	m Wkot D ou	m of Donto L one	2 071 2/5	
. 00	Pass through costs applicable to Program inpa	attent routine	Services (110	m wkst. D, Su	I OF Parts F and	3, 071, 265	5 50.
. 00	Pass through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	2, 013, 361	51
00	and IV)	FQ and 51				F 004 (0)	-
. 00 . 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		alated non-nh	veician anest	botist and	5, 084, 626 52, 043, 794	
. 00	medical education costs (line 49 minus line	5 1	erateu, non-pri	ysi ci all'allest	netist, and	52,043,794	+ 55
	TARGET AMOUNT AND LIMIT COMPUTATION	-					
. 00	Program discharges					0	
. 00 . 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)		
00	Bonus payment (see instructions)	9	5			C	
00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report u	ndated by the	market hasket		0.00	60
. 00	If line 53/54 is less than the lower of line					0.00	
	which operating costs (line 53) are less that	n expected cos					
~~	amount (line 56), otherwise enter zero (see	instructions)					
. 00 . 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ictions)				
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						1 00
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost report	ing period (See	C	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decem	her 31 of the	cost reportin	a period (See	c) 65
. 00	instructions) (title XVIII only)				g period (see		
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	ll only). For	C	66
00	CAH (see instructions)	a aaata thraud	December 21	of the east r	operting period	C	
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	1 December 31	of the cost f	eporting period	L L	67
. 00	Title V or XIX swing-bed NF inpatient routing	e costs after l	December 31 of	the cost rep	orting period	C	68
~~	(line 13 x line 20)		<pre>/// /= //</pre>				
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU		•			C	0 69
. 00	Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service c	ost per diem (l		•	, ,		71
. 00	Program routine service cost (line 9 x line		. (1:	(m. 25)			72
. 00 . 00	Medically necessary private room cost application Total Program general inpatient routine serv						73
. 00	Capital -related cost allocated to inpatient	•			Part II, column		75
	26, line 45)						
. 00 . 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76
00	Inpatient routine service cost (line 74 minu:						78
00	Aggregate charges to beneficiaries for excess	,	provider recor	ds)			79
00	Total Program routine service costs for comp		cost limitatio	n (line 78 mi	nus line 79)		80
00	Inpatient routine service cost per diem limi		1)				81
00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82
. 00	Program inpatient ancillary services (see ins		/				84
. 00	Utilization review - physician compensation	(see instruction					85
. 00	Total Program inpatient operating costs (sum		nrough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					9, 021	87
	Adjusted general inpatient routine cost per		÷line 2)			808.40	
. 00							

Health Financial Systems FLOY	D MEMORIAL HOSP	ITAL & HEALTH	SVS	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre	narod
				10 12/31/2013	5/27/2016 2:5	
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	6, 358, 154	48, 304, 319	0. 13162	7 7, 292, 576	959, 900	90.00
91.00 Nursing School cost	0	48, 304, 319	0.00000	0 7, 292, 576	0	91.00
92.00 Allied health cost	0	48, 304, 319	0.00000	0 7, 292, 576	0	92.00
93.00 All other Medical Education	0	48, 304, 319	0.00000	0 7, 292, 576	0	93.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 150044	Peri od:	Worksheet D-1	
			From 01/01/2015 To 12/31/2015		
		Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS	· · · ·			
1.00	Inpatient days (including private room days and swing-bed days,			59, 753	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days do not complete this line.		rivate room days,	59, 753 0	2.00 3.00
4.00	Semi-private room days (excluding swing-bed and observation be	d days)		50, 732	4.00
5.00	Total swing-bed SNF type inpatient days (including private room reporting period	m days) through Decembe		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room reporting period	5 / 0		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	5		0	8.00
9.00 10.00	Total inpatient days including private room days applicable to newborn days) Swing-bed SNF type inpatient days applicable to title XVIII on	0	5 5	1, 886	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII on	i ons)	5 ,	0	
12.00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX	ter 0 on this line)		0	
13.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX $$			0	13.00
14.00	after December 31 of the cost reporting period (if calendar year Medically necessary private room days applicable to the Program			0	14.00
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)				15.00 16.00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service:	s through December 31 (of the cost	0.00	17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to services	s after December 31 of	the cost	0.00	18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	f the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of	the cost	0.00	20.00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ting period (line	48, 263, 906 0	21.00 22.00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December :	31 of the cost reportio	ng period (line 6	0	23.00
24.00	x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost report	ng period (line	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 3 x line 20)	1 of the cost reporting	g period (line 8	0	25.00
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		0 48, 263, 906	
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed cl	narges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)		-	0	29.00
30.00 31.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0 0. 000000	•
31.00	Average private room per diem charge (line 29 ÷ line 3)	1110 20)		0.000000	1
33.00	Average semi-private room per diem charge (line 2) + line 4)			0.00	•
34.00	Average per diem private room charge differential (line 32 min	, .	ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line	e 31)		0.00	
36.00 37.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	0 48, 263, 906	36.00 37.00
37.00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				57.00
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	STMENTS			1
38.00	Adjusted general inpatient routine service cost per diem (see	instructions)		807.72	
39.00	Program general inpatient routine service cost (line 9 x line 3	-		1, 523, 360	
40.00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39			0 1, 523, 360	40.00
41.UU	Total Trogram general Tipatrent Toutine Service Cost (TINE 39	T IIIC 40)		1, 523, 300	41.00

	Financial Systems FLO TATION OF INPATIENT OPERATING COST FLO		Provi der		Period: From 01/01/2015		
					To 12/31/2015	Date/Time Pr 5/27/2016 2:	
	Cost Center Description	Total	Ti t Total	le XIX Average Per	Hospital Program Days	Cost Program Cost	
		I npati ent Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00 508.5	4.00 5 102	5.00 51,872	2 42.
	Intensive Care Type Inpatient Hospital Unit	ts				· · · · ·	
. 00 . 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	4, 945, 961 0	4,800	1, 030. 4 0. 0	-		3 43 0 44
. 00	BURN INTENSIVE CARE UNIT	0	0	0.0) 45
. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0.0	0 0	() 46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
						1.00	
. 00	Program inpatient ancillary service cost (V Total Program inpatient costs (sum of lines			(sac		1, 813, 45 ⁻ 3, 572, 096	
. 00	PASS THROUGH COST ADJUSTMENTS	3 41 through 40)		51137		3, 372, 070	J 47
. 00	Pass through costs applicable to Program ir	npatient routine	services (fro	n Wkst. D, sur	n of Parts I and	(50
. 00	<pre>III) Pass through costs applicable to Program in</pre>	npatient ancilla	rv services (f	rom Wkst. D. s	sum of Parts II	(51
~~	and IV)		, , , , , , , , , , , , , , , , , , ,				
. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		elated non-ph	vsician anesth	netist and) 52) 53
. 00	medical education costs (line 49 minus line	5 1					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program di scharges						54
. 00	Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					(56
. 00	Difference between adjusted inpatient opera	ating cost and ta	arget amount (ine 56 minus	line 53)		57
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost r	concrting period	ending 1006	indated and co	mounded by the) 58) 59
. 00	market basket	eporting period	ending 1990, 1		inpounded by the	0.00	
. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of lin which operating costs (line 53) are less th					(61
	amount (line 56), otherwise enter zero (see		ts (THES 54 X		the target		
. 00	Relief payment (see instructions)						62
. 00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	yment (see instru	uctions)			() 63
. 00	Medicare swing-bed SNF inpatient routine co	osts through Dece	ember 31 of the	e cost reporti	ng period (See	(64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	osts after Decem	her 31 of the (cost reporting	n period (See	(65
. 00	instructions)(title XVIII only)		ber of the t				
. 00	Total Medicare swing-bed SNF inpatient rout	tine costs (line	64 plus line	65)(title XVII	l only). For	() 66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi	ne costs through	h December 31 (of the cost re	eporting period	(67
	(line 12 x line 19)						
. 00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after l	December 31 of	the cost repo	orting period	(68 0
. 00	Total title V or XIX swing-bed NF inpatient					() 69
. 00	PART III - SKILLED NURSING FACILITY, OTHER Skilled nursing facility/other nursing faci				•		70
. 00	Adjusted general inpatient routine service	2		• •			71
. 00	Program routine service cost (line 9 x line						72
. 00	Medically necessary private room cost appli	0	•				73
. 00 . 00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient				Part II, column		74
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ 1	ine 2)					76
. 00	Program capital-related costs (line 75 ÷ 1						77
. 00	Inpatient routine service cost (line 74 mir	nus line 77)					78
. 00	Aggregate charges to beneficiaries for exce				1		79
. 00 . 00	Total Program routine service costs for com Inpatient routine service cost per diem lim	•	CUST IIMITATIO	i (iine /8 mir	ius i i ne 79)		80
00	Inpatient routine service cost per drem rim		1)				82
. 00	Reasonable inpatient routine service costs	(see instruction					83
. 00	Program inpatient ancillary services (see i	,					84
. 00 . 00	Utilization review - physician compensation Total Program inpatient operating costs (su						85
20	PART IV - COMPUTATION OF OBSERVATION BED PA						
. 00	Total observation bed days (see instruction					9,02	
. 00	Adjusted general inpatient routine cost per	e alom (Lino 07				807.72	2 88

Health Financial Systems FLOY	D MEMORIAL HOSP	ITAL & HEALTH	SVS	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015		
					5/27/2016 2:5	2 pm
			le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	6, 358, 154	48, 263, 906	0. 13173	7 7, 286, 442	959, 894	90.00
91.00 Nursing School cost	0	48, 263, 906	0.00000	0 7, 286, 442	0	91.00
92.00 Allied health cost	0	48, 263, 906	0.00000	0 7, 286, 442	0	92.00
93.00 All other Medical Education	0	48, 263, 906	0.00000	0 7, 286, 442	0	93.00

	inancial Systems FLOYD MEMORIAL HOSPITAL & IT ANCILLARY SERVICE COST APPORTIONMENT F		CCN: 150044	Peri od:	u of Form CMS-: Worksheet D-3	
				From 01/01/2015 To 12/31/2015	Date/Time Pre	narod
				10 12/31/2015	5/27/2016 2:5	2 pm
		Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs	
			TO charges	Charges	(col. 1 x	
				j	col. 2)	
			1.00	2.00	3.00	
	NPATIENT ROUTINE SERVICE COST CENTERS			24 (02 455		
	3000 ADULTS & PEDIATRICS 3100 I NTENSI VE CARE UNIT			26, 693, 455 3, 985, 412		30.00
	3200 CORONARY CARE UNIT			3, 903, 412		32.00
	3300 BURN I NTENSI VE CARE UNI T			0		33.00
	3400 SURGI CAL I NTENSI VE CARE UNI T			0		34.0
	4000 SUBPROVI DER – I PF			0		40.00
41.00 0·	4100 SUBPROVI DER – I RF			0		41.00
12.00 0	4200 SUBPROVI DER			0		42.00
	4300 NURSERY					43.00
	NCI LLARY SERVI CE COST CENTERS					
	5000 OPERATING ROOM		0. 1161		3, 966, 436	1
	5100 RECOVERY ROOM 5200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
	5300 ANESTHESI OLOGY		0. 5609		396, 675 0	
	5400 RADI OLOGY-DI AGNOSTI C		0. 2258		1, 879, 404	•
	5500 RADI OLOGY-THERAPEUTI C		0.0000		1, 07 7, 404	
	5600 RADI OL SOTOPE		0.0000		0	
	5700 CT SCAN		0. 0349		318, 097	
	5800 MRI		0. 0365		135, 713	
	5900 CARDI AC CATHETERI ZATI ON		0. 0485		903, 347	
50.00 0	6000 LABORATORY		0. 1312	67 24, 758, 176	3, 249, 931	60.00
50.01 0	6001 BLOOD LABORATORY		0.0000		0	60. 0 ²
	6100 PBP CLINICAL LAB SERVICES-PRGM		0.0000		0	
	6200 WHOLE BLOOD & PACKED RED BLOOD		0.0000		0	
	6300 BLOOD STORING PROCESSING & TRA		0.0000		0	
	6400 I NTRAVENOUS THERAPY		0. 2110		10, 385	
	6500 RESPIRATORY THERAPY		0. 1504		1, 679, 741	
	6600 PHYSI CAL THERAPY 6700 OCCUPATI ONAL THERAPY		0. 2124		660, 975 0	1
1	6800 SPEECH PATHOLOGY		0.0000		174, 622	
	6900 ELECTROCARDI OLOGY		0. 0789		801, 970	
	7000 ELECTROENCEPHALOGRAPHY		0. 5451		36, 518	
	7001 SLEEP DI SORDER		0. 1383		2, 576	
	7100 MEDICAL SUPPLIES CHARGED TO PAT		0.6371		4, 165, 004	
72.00 0	7200 I MPL. DEV. CHARGED TO PATIENTS		1.0003		6, 963, 669	72.0
73.00 0	7300 DRUGS CHARGED TO PATIENTS		0. 2284	82 25, 492, 251	5, 824, 520	73.0
74.00 0	7400 RENAL DI ALYSI S		0.0000	00 0	0	74.0
	7500 ASC (NON-DISTINCT PART)		0.0000		0	
	3950 NUTRI TI ON/DI ABETES		0.0000		0	
	7697 CARDI AC REHABI LI TATI ON		0. 5309	68 1, 590	844	76.9
	UTPATI ENT SERVI CE COST CENTERS		0.0000	00	0	
	8800 RURAL HEALTH CLINIC		0.0000		0	
	8900 FEDERALLY QUALI FI ED HEALTH CENTER 9000 CLI NI C		0.0000		0 125, 129	
	9100 EMERGENCY		0. 2091		1, 116, 244	
	9200 OBSERVATION BEDS (NON-DISTINCT		0. 1320		714, 476	
0	THER REIMBURSABLE COST CENTERS		0.777	0,0,100	, , , , , , , , , , , , , , , , , , , ,	1
	9400 HOME PROGRAM DI ALYSI S		0.0000	00 0	0	94.00
	9500 AMBULANCE SERVICES				0	95.00
	9600 DURABLE MEDI CAL EQUI P-RENTED		0.0000	00 0	0	
	9700 DURABLE MEDI CAL EQUI P-SOLD		0.0000		0	
200.00	Total (sum of lines 50-94 and 96-98)			172, 139, 689	33, 126, 276	
201.00	Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1	172, 139, 689		202.00

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	ovi der	CCN: 150044	Per	i od:	Worksheet D-3	3
	011 401			m 01/01/2015 12/31/2015	Date/Time Pre	
					5/27/2016 2:5	52 pm
	Tit	tle XIX		Hospi tal	Cost	
Cost Center Description		Ratio of Co		Inpatient	Inpatient	
		To Charges	5	Program Charges	Program Costs (col. 1 x	
				charges	col. 2)	
		1.00		2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00 03000 ADULTS & PEDIATRICS				1, 723, 950		30.
I. OO O3100 I NTENSI VE CARE UNI T 2. OO O3200 CORONARY CARE UNI T				279, 650 0		31.
3. 00 03300 BURN I NTENSI VE CARE UNI T				0		33.
I. OO O3400 SURGI CAL I NTENSI VE CARE UNI T				0		34.
0. 00 04000 SUBPROVI DER - I PF				õ		40.
. 00 04100 SUBPROVI DER – I RF				0		41.
2. 00 04200 SUBPROVI DER				0		42.
3. 00 04300 NURSERY				0		43.
ANCI LLARY SERVI CE COST CENTERS		0.444	1 - 4	4 744 404	000.005	1 50
0. 00 05000 0PERATING ROOM 1. 00 05100 RECOVERY ROOM		0.116		1, 741, 606	202, 295	
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0 108, 959	0 61, 118	
3. 00 05300 ANESTHESI OLOGY		0.0000		106, 959	01, 118	
I. OO 05500 ANESTINEST OLOGI		0. 2258		448, 383	101, 264	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000		0	0	
5. 00 05600 RADI OI SOTOPE		0.0000		0	0	
7. 00 05700 CT SCAN		0. 0349	964	516, 388	18, 055	57.
3. 00 05800 MRI		0. 0365	592	207, 097	7, 578	58.
P. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0485		716, 129	34, 735	
0. 00 06000 LABORATORY		0. 1312		1, 619, 180	212, 545	
0.01 06001 BLOOD LABORATORY		0.0000		0	0	
1. 00 06100 PBP_CLINICAL_LAB_SERVICES-PRGM		0.0000		0	0	
2. OO 06200 WHOLE BLOOD & PACKED RED BLOOD 3. OO 06300 BLOOD STORING PROCESSING & TRA		0.0000		0	0	
I. OO OGGOO BLOOD STORTING FROCESSING & TRA		0. 2110		4, 482	946	
5. 00 06500 RESPI RATORY THERAPY		0. 1504		845, 035	127, 162	
5. 00 06600 PHYSI CAL THERAPY		0. 2124		121, 351	25, 777	
7. 00 06700 OCCUPATI ONAL THERAPY		0.0000		0	0	
3. 00 06800 SPEECH PATHOLOGY		0. 3197	725	21, 946	7, 017	68.
P. 00 06900 ELECTROCARDI OLOGY		0.0789	947	466, 509	36, 829	69.
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 5451		6, 065	3, 307	
0. 01 07001 SLEEP DI SORDER		0. 1383		42,060	5, 818	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT		0.637		304, 984	194, 326	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3.00 07300 DRUGS CHARGED TO PATIENTS		1.0003		204, 036 1, 993, 474	204, 110 455, 473	
I. OO O7400 RENAL DIALYSIS		0. 0000		1, 993, 474	455, 475	
5. 00 07500 ASC (NON-DI STINCT PART)		0.0000		0	0	
5. 00 03950 NUTRI TI ON/DI ABETES		0.0000		ō	0	
5. 97 07697 CARDI AC REHABI LI TATI ON		0. 5309	968	0	0	76.
OUTPATIENT SERVICE COST CENTERS		1				
3. 00 08800 RURAL HEALTH CLINIC		0.0000		0	0	
2. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	0	
0. 00 09000 CLI NI C 1. 00 09100 EMERGENCY		0.2691		48, 200	12, 975	
1. 00 09100 EMERGENCY 2. 00 09200 OBSERVATION BEDS (NON-DISTINCT		0. 1526		438, 926 43, 888	67, 023 35, 098	
OTHER REIMBURSABLE COST CENTERS		0.779	, 20	43,000	55, 040	72.
I. OO O9400 HOME PROGRAM DI ALYSI S		0.0000	000	0	0	94.
5. 00 09500 AMBULANCE SERVICES				J	0	95.
5. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.0000	000	О	0	
7. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.0000	000	О	0	97.
00.00 Total (sum of lines 50-94 and 96-98)				9, 898, 698	1, 813, 451	
11.00 Less PBP Clinic Laboratory Services-Program only charges (li	ne 61)			0		201.
02.00 Net Charges (line 200 minus line 201)		1		9, 898, 698		202.

	Financial Systems FLOYD MEMORIAL HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT		CCN: 150044	Period: From 01/01/2015	u of Form CMS Worksheet E Part A	2002-10
				To 12/31/2015		
		Ti tl	e XVIII	Hospi tal	PPS	
			0	1.00	2.00	
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0		1.00
1.00	DRG amounts other than outlier payments for discharges occurrin	ng prior		40, 585, 890		1.00
1.02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurrin	ng on or		13, 279, 158		1.02
	after October 1 (see instructions)	0				
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	-		0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0		1.04
2.00	Outlier payments for discharges. (see instructions)			451, 858		2.00
2. 01 2. 02	Outlier reconciliation amount	nc)		0		2.01 2.02
2.02	Outlier payment for discharges for Model 4 BPCI (see instruction Managed Care Simulated Payments)IIS)		11, 795, 516		3.00
4.00	Bed days available divided by number of days in the cost report	i ng		186. 28		4.00
	period (see instructions) Indirect Medical Education Adjustment					_
5.00	FTE count for allopathic and osteopathic programs for the most			0.00		5.00
6.00	cost reporting period ending on or before 12/31/1996. (see instr FTE count for allopathic and osteopathic programs which meet th			0.00		6.00
	criteria for an add-on to the cap for new programs in accordance	e with 42				
7.00	CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified ur	nder 42		0.00		7.00
7 01	CFR §412.105(f)(1)(iv)(B)(1)			0.00		7 01
7.01	ACA Section 5503 reduction amount to the IME cap as specified u CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July			0.00		7.01
0 00	then see instructions.	ic and		0.00		8.00
8.00	Adjustment (increase or decrease) to the FTE count for allopath osteopathic programs for affiliated programs in accordance with			0.00		8.00
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67					
8. 01	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot	s under		0.00		8.01
	section 5503 of the ACA. If the cost report straddles July 1, 2					
8. 02	instructions. The amount of increase if the hospital was awarded FTE cap slot	s from a		0.00		8.02
	closed teaching hospital under section 5506 of ACA. (see instru	ıcti ons)				
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines and 8,02) (see instructions)	5 (8, 8,01		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the currer	nt year		0.00		10.00
11.00	from your records FTE count for residents in dental and podiatric programs.			0.00		11.00
12.00	Current year allowable FTE (see instructions)			0.00		12.00
13.00 14.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year	ended on		0. 00 0. 00		13.00
	or after September 30, 1997, otherwise enter zero.					
15.00 16.00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			0. 00 0. 00		15.00
17.00	Adjustment for residents displaced by program or hospital closu	ire		0.00		17.00
18.00 19.00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			0. 00 0. 000000		18.00 19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000		20.00
21.00 22.00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)			0. 000000		21.00
22.00	IME payment adjustment - Managed Care (see instructions)			0		22.00
23.00	Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE resider		the MMA	0.00		23.00
	slots under 42 Sec. 412.105 (f)(1)(iv)(C).	n cap				
24.00 25.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the lo	wer of		0. 00 0. 00		24.00 25.00
20.00	line 23 or line 24 (see instructions)	Mich Of		0.00		25.00
26.00 27.00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000		26.00 27.00
28.00	IME add-on adjustment amount (see instructions)			0.000000		28.00
28. 01 29. 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28)			0		28.01 29.00
29.00	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29.00
20.00	Disproportionate Share Adjustment Percentage of SSL reginient nationt days to Medicare Part A pat	iont days		E co		20.00
30.00	Percentage of SSI recipient patient days to Medicare Part A pat (see instructions)	nent uays		5.00		30.00
31.00	Percentage of Medicaid patient days (see instructions)			14.51 10.51		31.00
32.00 33.00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)			19. 51 5. 43		32.00 33.00
	Disproportionate share adjustment (see instructions)			731, 219		34.00

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	Financial Systems FLOYD MEMORIAL HOSPI ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150044	Period: From 01/01/2015	u of Form CMS-2 Worksheet E Part A	2002-10
			To 12/31/2015		
		Title XVIII	Hospi tal	PPS On/After	
			Prior to October 1	October 1	
	Uncompensated Care Adjustment	0	1.00	2.00	
35.00	Total uncompensated care amount (see instructions)		7, 647, 644, 885	6, 406, 145, 534	35.00
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero,		0. 000290725 2, 223, 363	0. 000271767 1, 740, 976	35.01 35.02
3 <u>3</u> . 02	enter zero on this line) (see instructions)		2, 223, 303	1, 740, 970	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1, 662, 953	437, 622	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2, 100, 575		36.00
40.00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges on Worksheet S-3, Part I	discharges (lines 40 throug	gh 46) 0		40.00
40.00	excluding discharges for MS-DRGs 652, 682, 683, 684 and		0		40.00
41.00	685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.00
41.01	682, 683, 684 an 685. (see instructions) Total ESRD Medicare covered and paid discharges excluding		0		41.01
42.00	MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
43.00	qualify for adjustment) Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.00
44.00	682, 683, 684 an 685. (see instructions) Ratio of average length of stay to one week (line 43		0. 000000		44.00
45.00	divided by line 41 divided by 7 days) Average weekly cost for dialysis treatments (see		0.00		45.00
46.00	instructions) Total additional payment (line 45 times line 44 times line		0		46.00
47.00	41.01) Subtotal (see instructions)		57, 148, 700		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		57, 148, 700		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		4, 465, 158		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00 54.00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies		0 9, 157		53.00 54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see		0		56.00
57.00	intructions) Routine service other pass through costs (from Wkst. D, Dt. Ll. column 0. Lines 20 through 25)		0		57.00
58.00	Pt. III, column 9, lines 30 through 35). Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		61, 623, 015		59.00
60.00 61.00	Primary payer payments Total amount payable for program beneficiaries (line 59		120, 264 61, 502, 751		60.00 61.00
	minus line 60)				
62.00 63.00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries		5, 596, 448 153, 090		62.00 63.00
64. 00	Allowable bad debts (see instructions)		250, 323		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		162, 710		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		87, 692		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		55, 915, 923		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70. 00 70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT		0		70.00 70.50
70. 89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70. 90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70. 92 70. 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)		0 -70, 836		70.92
70.94	HRR adjustment amount (see instructions)		-401, 135		70.94
	Recovery of accel erated depreciation		-401, 133		70

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ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150044		i od: m 01/01/2015 12/31/2015	Worksheet E Part A Date/Time Pre 5/27/2016 2:5	epared: 52 pm
		Title XVIII		Hospi tal	PPS	
				Prior to October 1	On/After October 1	
		0		1.00	2.00	
0. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)		0	0		70.96
0. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)		0	0		70.97
0. 98	Low Volume Payment-3			0		70.98
0.99	5			150, 156		70.99
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			55, 293, 796		71.00
1.01	Sequestration adjustment (see instructions)			1, 105, 876		71.01
	Interim payments			54, 315, 966		72.00
	Tentative settlement (for contractor use only)			0		73.00
4.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)			-128, 046		74.00
5.00	accordance with CMS Pub. 15-2, chapter 1, §115.2			489, 198		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
0.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0		90.00
1.00	Capital outlier from Wkst. L, Pt. I, line 2			0		91.00
2.00	instructions)			0		92.00
93.00	instructions)			0		93.00
	The rate used to calculate the time value of money (see instructions)			0.00		94.00
95.00	Time value of money for operating expenses (see instructions)			0		95.00
6.00	Time value of money for capital related expenses (see			0		96.00
	instructions)				0 (1.6) 10 (1	
			Р	1.00	0n/After 10/1 2.00	
	HSP Bonus Payment Amount					
00.00	HSP bonus amount (see instructions)			0	C	100.00
01 07	HVBP Adjustment for HSP Bonus Payment			0.000000000	0.000000000	101 07
	HVBP adjustment factor (see instructions)			0. 000000000	0. 000000000	
02.00	HVBP adjustment amount for HSP bonus payment (see instruction	1S)		0	(102.00
~~ ~~	HRR Adjustment for HSP Bonus Payment			0.0000	0.0000	100.01
U3. UL	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions			0.0000	0.0000	103.00

		WENNOR AL 11031					102 10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/27/2016 2:5	pared:
				e XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	40, 585, 890	40, 585, 89	0	40, 585, 890	1.01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	13, 279, 158		13, 279, 158	13, 279, 158	1.02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0		0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	451, 858	351, 65	0 100, 208	451, 858	2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0 0	0	2.01
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments Indirect Medical Education Adjustment	3.00	11, 795, 516	8, 802, 08	5 2, 993, 431	11, 795, 516	4.00
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 00000	0 0. 000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0		o o	0	6.00
6. 01	IME payment adjustment for managed care (see instructions)		0		0 0	0	6.01
	Indirect Medical Education Adjustment for the	e Add-on for S	ection 422 of t	he MMA			
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000		0 0. 000000		7.00
8.00	IME adjustment (see instructions)	28.00	0		0 0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28. 01	0		0 0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		o o	0	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0		0 0	0	9.01
	Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0543	0. 054	3 0. 0543		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	731, 219	550, 95	4 180, 265	731, 219	11.00
11.01	Uncompensated care payments	36.00	2, 100, 575	1, 662, 95	3 437, 622	2, 100, 575	11.01
	Additional payment for high percentage of ES	RD beneficiary					
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
13.00	Subtotal (see instructions)	47.00	57, 148, 700	43, 151, 44	7 13, 997, 253	57, 148, 700	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see		0		0 0	0	14.00
15.00	instructions) Total payment for inpatient operating costs	49.00	57, 148, 700	43, 151, 44	7 13, 997, 253	57, 148, 700	15.00
16.00	(see instructions) Payment for inpatient program capital	50.00	4, 465, 158				
17.00	Special add-on payments for new technologies		9, 157	9, 15		9, 157	
17.01	Net organ aquisition cost	55.00	0		0 0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.00
19.00	SUBTOTAL			46, 517, 94	4 15, 105, 071	61, 623, 015	19.00

FLOYD MEMORIAL HOSPITAL & HEALTH SVS In Lieu of Form CMS-2552-10

Health Financial Systems

OSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der	CCN: 150044	Period: From 01/01/2015 To 12/31/2015		pared:
			e XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
0.00 Capital DRG other than outlier	1.00	4, 257, 520	3, 203, 4			
0.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0		
1.00 Capital DRG outlier payments	2.00	36, 060	24, 78	80 11, 280	36, 060	
1.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
2.00 Indirect medical education percentage (see instructions)	5.00	0. 0000	0.000	0.0000		22.00
3.00 Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
4.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0403	0.040	0. 0403		24.00
5.00 Disproportionate share adjustment (see instructions)	11.00	171, 578	129, 0	99 42, 479	171, 578	25.00
6.00 Total prospective capital payments (see instructions)	12.00	4, 465, 158	3, 357, 34	40 1, 107, 818	4, 465, 158	26.00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt.				
	· · · · · · · · · · · · · · · · · · ·	A)				
7.00	0	1.00	2.00	3.00	4.00	07.0
7.00	70.0/					27.0
8.00 Low volume adjustment prior to October 1	70. 96	0		0	0	
9.00 Low volume adjustment on or after October 1	70. 97	0		0	0	
0.00 HVBP payment adjustment (see instructions)	70. 93	-70, 836	-21, 19			
0.01 HVBP payment adjustment for HSP bonus	70. 90	0		0 0	0	30.0
payment (see instructions)	70.04	404 405	0/4 0		404 405	01.0
1.00 HRR adjustment (see instructions)	70.94	-401, 135				
1.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.0
					(Amt. to	
					Wkst. E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
2.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 150, 156	150, 156	32.00
00.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150044	Peri od: From 01/01/2015 To 12/31/2015		pare 2 pm
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
	Medical and other services (see instructions)			42, 736	
00	Medical and other services reimbursed under OPPS (see instruct	tions)		28, 803, 966	
00 00	PPS payments Outlier payment (see instructions)			31, 671, 440 12, 188	
00	Enter the hospital specific payment to cost ratio (see instructions)	ctions)		0.000	
00	Line 2 times line 5			0.000	
00	Sum of line 3 plus line 4 divided by line 6			0.00	7
00	Transitional corridor payment (see instructions)			0	8
00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 13, line 200		0	
	Organ acquisitions			0	10.
. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			42, 736	11
	Reasonabl e charges				1
. 00	Ancillary service charges			203, 895	12.
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ine 69)		0	
. 00	Total reasonable charges (sum of lines 12 and 13)			203, 895	14
00	Customary charges Aggregate amount actually collected from patients liable for p	anymont for carvings on	a charge basis	0	115
	Amounts that would have been realized from patients liable for			0	
. 00	had such payment been made in accordance with 42 CFR §413.13(e		on a onargebasi s	0	
. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17
	Total customary charges (see instructions)			203, 895	
. 00	Excess of customary charges over reasonable cost (complete onl	ly if line 18 exceeds l	ine 11) (see	161, 159	19
00	instructions) Excess of reasonable cost over customary charges (complete onl	ly if line 11 exceeds 1	ino 19) (coo	0	20
. 00	instructions)	Ty IT THE IT exceeds I	The TO) (366	0	20
. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see		42, 736	21	
	Interns and residents (see instructions)			0	22
	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	
. 00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			31, 683, 628	24
. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25
	Deductibles and Coinsurance relating to amount on line 24 (for	r CAH, see instructions)	6, 358, 076	
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	plus the sum of lines 2	2 and 23] (see	25, 368, 288	27
	instructions)			-	
	Direct graduate medical education payments (from Wkst. E-4, li	ine 50)		0	
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			25, 368, 288	29
	Primary payer payments			38, 690	
	Subtotal (line 30 minus line 31)			25, 329, 598	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			910, 310 591, 702	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	ructions)		708, 663	
	Subtotal (see instructions)			25, 921, 300	
. 00	MSP-LCC reconciliation amount from PS&R			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions			0	39
	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	cea aevices (see instru	cuons)	0	39
	Subtotal (see instructions)			25, 921, 300	
	Sequestration adjustment (see instructions)			518, 426	
	Interim payments		25, 223, 097		
	Tentative settlement (for contractors use only)			0	
	Balance due provider/program (see instructions)	and with ONC Duby 15 C	obopt 1	179, 777	
. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	chapter I,	0	44
	TO BE COMPLETED BY CONTRACTOR				
. 00	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	
	Time Value of Money (see instructions)			0	93

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 150044	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/27/2016 2:53	pare
			e XVIII	Hospi tal	PPS	
		Inpatier	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider	1.00	54, 236, 5		25, 143, 697	1.
00	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		01,200,0	0	0	2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
D1	ADJUSTMENTS TO PROVIDER	07/17/2015	79.4	00 07/17/2015	79,400	3
02		0//1//2013	, , , ,	0	0	3
03				0	0	3
04				0	0	3
05				0	0	3
- 0	Provider to Program	1				
50 51	ADJUSTMENTS TO PROGRAM			0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		79, 4	00	79, 400	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		54, 315, 9	66	25, 223, 097	4
	TO BE COMPLETED BY CONTRACTOR		•			
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
D1	TENTATI VE TO PROVI DER			0	0	5
)2				0	0	5
23	Provider to Program			0	0	5
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1)2	SETTLEMENT TO PROVIDER		100 0	0	179, 777 0	6
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		128, 0 54, 187, 9		25, 402, 874	6
00	Total moundare program traditity (see fistractions)		1 34, 107, 9	Contractor Number	NPR Date (Mo/Day/Yr)	/
			Э С	1.00	2.00	
00	Name of Contractor					8

Heal th	Financial Systems FLOYD MEMORIAL HOSPITA	L & HEALTH SVS	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150044	Peri od:	Worksheet E-1	
			From 01/01/2015		
			To 12/31/2015	Date/Time Pre 5/27/2016 2:5	
		Title XVIII	Hospi tal	PPS	<u> 2 μιι</u>
			110301 tui	115	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 lir	e 14	13, 292	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12		29,006	2.00
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12		55, 532	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			903, 651, 585	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li	ne 20		10, 633, 214	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of co	ertified HIT technology	Wkst. S-2, Pt. I	0	7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			712, 008	
9.00	Sequestration adjustment amount (see instructions)			14, 240	9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		697, 768	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			661, 720	
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and li	ne 31) (see instructio	ns)	36, 048	32.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150044	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	epare
				5/27/2016 2:5	<u>,2 pr</u>
		Title XIX	Hospi tal	Cost Outpatient	
			Inpatient 1.00	2.00	-
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR 2		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
. 00	Inpatient hospital/SNF/NF services		3, 572, 096		1 1
. 00	Medical and other services			2, 307, 341	2
00	Organ acquisition (certified transplant centers only)		0	1	3
00	Subtotal (sum of lines 1, 2 and 3)		3, 572, 096	2, 307, 341	
00	Inpatient primary payer payments		0	1	5
00	Outpatient primary payer payments			0	-
00	Subtotal (line 4 less sum of lines 5 and 6)		3, 572, 096	2, 307, 341	7
	COMPUTATION OF LESSER OF COST OR CHARGES				4
~~	Reasonabl e Charges				
. 00	Routine service charges		0 000 600	10 040 070	8
00). 00	Ancillary service charges Organ acquisition charges, net of revenue		9, 898, 698	12, 348, 879	10
	Incentive from target amount computation		0	1	11
	Total reasonable charges (sum of lines 8 through 11)		9, 898, 698	12, 348, 879	
2.00	CUSTOMARY CHARGES		7, 070, 070	12, 340, 079	1 12
3.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13
0.00	basi s	Services on a charge	0		
4.00	Amounts that would have been realized from patients liable for	payment for services (on 0	0	14
	a charge basis had such payment been made in accordance with 4		-	-	
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	15
5.00	Total customary charges (see instructions)	9, 898, 698	12, 348, 879	16	
7.00	Excess of customary charges over reasonable cost (complete onl	6, 326, 602	10, 041, 538	17	
	line 4) (see instructions)				
3.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds lin	ne 0	0	18
	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see instr		0	0	
1.00	Cost of covered services (enter the lesser of line 4 or line 1		3, 572, 096	2, 307, 341	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provi		0	1
	Other than outlier payments Outlier payments		0	0	
	Program capital payments		0	0	23
	Capital exception payments (see instructions)		0	1	25
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		3, 572, 096	-	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0,012,010	2,007,011	1 - 1
0. 00	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	3, 572, 096	2, 307, 341	
2.00	Deducti bl es		0	0	
3.00	Coinsurance		0	0	33
1.00	Allowable bad debts (see instructions)		0	0	
5.00	Utilization review		0	1	35
5.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	3, 572, 096	2, 307, 341	36
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		3, 572, 096	2, 307, 341	
	Direct graduate medical education payments (from Wkst. E-4)		0		39
	Total amount payable to the provider (sum of lines 38 and 39)		3, 572, 096	2, 307, 341	
	Interim payments		3, 572, 096	2, 307, 341	
2.00	Balance due provider/program (line 40 minus line 41)		0	0	42
	Protested amounts (nonallowable cost report items) in accordar		0	0	43

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column on			eriod: rom 01/01/2015	Worksheet G	
iu-t	ype accounting records, comprete the deneral rund cordinin on	(y)		o 12/31/2015	Date/Time Pre 5/27/2016 2:5	
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	33, 164, 258	C	0	0	1
00	Temporary investments	0	-	-	0	
00	Notes receivable	00 505 405	, s		0	
00 00	Accounts receivable Other receivable	99, 525, 135 1, 033, 190		-	0	
00	Allowances for uncollectible notes and accounts receivable			-	0	
00	Inventory	5, 388, 280		-	0	
00	Prepai d'expenses	2, 704, 163	c	0	0	8
00	Other current assets	0	C	-	0	
00	Due from other funds		0		0	
00	Total current assets (sum of lines 1-10) FIXED ASSETS	115, 387, 022	C	0	0	11
00	Land	6, 258, 517	C	0	0	12
00	Land improvements	3, 751, 699	c	0	0	13
00	Accumulated depreciation	-3, 290, 447		-	0	
00	Buildings	135, 782, 616		-	0	
00 00	Accumulated depreciation Leasehold improvements	-62, 494, 198 4, 528, 086		-	0	
	Accumul ated depreciation	-3, 110, 860		-	0	
	Fixed equipment	17, 734, 857		-	0	
00	Accumulated depreciation	-13, 723, 041	0	0	0	20
00	Automobiles and trucks	0	C	-	0	
	Accumulated depreciation	0	0	-	0	
	Major movable equipment Accumulated depreciation	140, 478, 011 -112, 237, 569		-	0	
	Minor equipment depreciable	538, 912		-	0	
	Accumulated depreciation	-318, 943		-	0	
00	HIT designated Assets	0	C	0	0	27
	Accumulated depreciation	0	0	-	0	
	Minor equipment-nondepreciable		0		0	
	Total fixed assets (sum of lines 12-29) OTHER ASSETS	113, 897, 640	C	0	0	30
	Investments	8, 034, 669	C	0	0	31
00	Deposits on Leases	0	0	0	0	32
00	Due from owners/officers	0	C	-	0	
	Other assets	65, 259, 933		-	0	
	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	73, 294, 602 302, 579, 264			0	
00	CURRENT LIABILITIES	302, 379, 204		0	0	1 30
00	Accounts payable	16, 553, 735	C	0	0	37
00	Salaries, wages, and fees payable	13, 354, 739			0	
	Payroll taxes payable	0	0		0	
	Notes and Loans payable (short term) Deferred income	9, 341, 551 0		Ŭ	0	
00	Accelerated payments			0	0	41
00	Due to other funds	5, 356, 728	c d	0	0	
00	Other current liabilities	26, 511, 724		0	0	
00	Total current liabilities (sum of lines 37 thru 44)	71, 118, 477	C	0	0	45
~~	LONG TERM LIABILITIES					
	Mortgage payable Notes payable	0			0 0	
00 00	Unsecured Loans			-	0	
	Other long term liabilities	98, 120, 939	-	-	0	
	Total long term liabilities (sum of lines 46 thru 49	98, 120, 939		0	0	50
00	Total liabilites (sum of lines 45 and 50)	169, 239, 416	0	0	0	51
00	CAPITAL ACCOUNTS	122 220 042	1			-
00 00	General fund balance Specific purpose fund	133, 339, 848	l c			52
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant				0	
00	Plant fund balance - reserve for plant improvement,				0	58
00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	133, 339, 848	c	_	0	59
	FILES JZ LIILU JOI ALIGES (JUILUL FILES JZ LIILU JO)	1 100,007,040		1 0		60

STATEMENT OF	CHANGES IN FUND BALANCES		Provi der	er CCN: 150044		iod: m 01/01/2015 12/31/2015			
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund		
		1.00	2.00	3.00		4.00	5.00	_	
2.00 Net ind 3.00 Total (4.00 Addition 5.00 6.00 7.00 8.00 9.00 10.00 Total a 11.00 Subtota 12.00 Deducti 13.00 14.00 15.00 16.00 17.00	<pre>00 Net income (loss) (from Wkst. G-3, line 29) 00 Total (sum of line 1 and line 2) 00 Additions (credit adjustments) (specify) 00 00 00 00 00 00 00 00 00 00 00 00 00</pre>		129, 588, 704 3, 751, 144 133, 339, 848 0 133, 339, 848	3.00		4.00 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$
	alance at end of period per balance (line 11 minus line 18)	Endowment Fund	133, 339, 848 Pl ant	Fund		0			19.00
1.00 Fund ba	alances at beginning of period	6.00	7.00	8.00	0				1.00
2.00 Net inc 3.00 Total ((some (loss) (from Wkst. G-3, line 29) (sum of line 1 and line 2) (suns (credit adjustments) (specify)	0	0 0 0 0 0		0				2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 Total a 11.00 Subtota 12.00 Deducti 13.00 14.00 15.00 16.00 17.00	additions (sum of line 4-9) al (line 3 plus line 10) ons (debit adjustments) (specify) deductions (sum of lines 12-17)	0 0	0 0 0 0 0 0		0 0				9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00

TATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 150044	Period: From 01/01/2015 To 12/31/2015	Worksheet G-2 Parts I & II Date/Time Pre 5/27/2016 2:5	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
. 00	Hospi tal		67, 794, 6	96	67, 794, 696	1.00
. 00	SUBPROVIDER - IPF			0	0	2.00
. 00	SUBPROVIDER - IRF			0	0	3.00
. 00	SUBPROVI DER			0	0	
. 00	Swing bed - SNF			0	0	
. 00	Swing bed - NF			0	0	
. 00	SKILLED NURSING FACILITY			0	0	7.00
. 00	NURSING FACILITY			0	0	
. 00	OTHER LONG TERM CARE			0	0	
0.00	Total general inpatient care services (sum of lines 1-9)		67, 794, 6	96	67, 794, 696	10.00
	Intensive Care Type Inpatient Hospital Services					
1.00	I NTENSI VE CARE UNI T		8, 045, 2		8,045,238	
2.00	CORONARY CARE UNIT			0	0	12.00
3.00	BURN INTENSIVE CARE UNIT			0	0	
4.00	SURGI CAL I NTENSI VE CARE UNI T			0	0	14.00
5.00	OTHER SPECIAL CARE (SPECIFY)					15.00
6.00	Total intensive care type inpatient hospital services (sum of li 11-15)	nes	8, 045, 2		8, 045, 238	
7.00	Total inpatient routine care services (sum of lines 10 and 16)		75, 839, 9		75, 839, 934	
8.00	Ancillary services		319, 804, 7		754, 815, 667	
9.00	Outpatient services		16, 115, 0		72, 778, 860	
0.00	RURAL HEALTH CLINIC			0 0	0	
1.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
2.00	HOME HEALTH AGENCY			5, 619, 278	5, 619, 278	
3.00	AMBULANCE SERVICES			0 0	0	
4.00	CMHC			0	0	
4.10				0 0	0	
5.00	AMBULATORY SURGICAL CENTER (D. P.)			0 0	0	
6.00	HOSPICE		00 101 1		0	
7.00	OTHER	WI+	30, 131, 1			
8.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to G-3, line 1)	WKST.	441, 890, 8	30 579, 639, 826	1, 021, 530, 656	28.00
	PART II - OPERATING EXPENSES					
9.00	Operating expenses (per Wkst. A, column 3, line 200)			324, 980, 013		29.00
0.00	EXPENSES NOT INCLUDED ON WORKSHEET A		26, 411, 7			30.00
1.00			20, 111, 1	0		31.00
2.00				0		32.00
3.00				0		33.00
4.00				0		34.00
5.00				0		35.00
6.00	Total additions (sum of lines 30-35)			26, 411, 781		36.00
7.00	DEDUCT (SPECIFY)			0		37.00
8.00				0		38.00
9.00				0		39.0
0.00				0		40.0
1.00				0		41.00
2.00	Total deductions (sum of lines 37-41)			0		42.0
3.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		351, 391, 794		43.00
	to Wkst. G-3, line 4)					

Heal th	Financial Systems FLOYD MEMORIAL HOSPITAL	& HEALTH SVS	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 150044	Peri od:	Worksheet G-3	
			From 01/01/2015 To 12/31/2015		
	· · · · · · · · · · · · · · · · · · ·			5/27/2016 2:5	2 pm
				1 00	
1 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		1.00	1.00
1.00 2.00	Less contractual allowances and discounts on patients' accounts			676, 444, 801	2.00
2.00	Net patient revenues (line 1 minus line 2)	·		345, 085, 855	3.00
3.00 4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43			345, 085, 855	
4.00 5.00	Net income from service to patients (line 3 minus line 4)	·)		-6, 305, 939	4.00 5.00
5.00	OTHER INCOME			-0, 303, 939	5.00
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			1, 829, 758	7.00
8.00	Revenues from telephone and other miscellaneous communication s	ervi ces		1,027,700	8.00
9.00	Revenue from tel evision and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			754, 347	11.00
12.00	Parking lot receipts			209, 344	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			1, 077, 063	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 that	n 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			3, 350	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			137, 927	
22.00	Rental of hospital space			93, 258	
23.00	Governmental appropriations			4, 047, 182	23.00
24.00	IDENTIFIED ON TRIAL BALANCE			1, 904, 854	
25.00	Total other income (sum of lines 6-24)			10, 057, 083	
26.00	Total (line 5 plus line 25)			3, 751, 144	
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)		ļ	3, 751, 144	29.00

	Financial Systems SIS OF PROVIDER-BASED HOME HEALT		MEMORIAL HOSP		CCN: 150044 P	Period:	u of Form CMS-2 Worksheet H	2002
				HHA CCN:		rom 01/01/2015 o 12/31/2015	Date/Time Pre	narc
				TITIA CON.	157152 1		5/27/2016 2:5	52 pn
						Home Health Agency I	PPS	
		Sal ari es	Empl oyee	Transportatio	Contracted/Pu		Total (sum of	
			Benefits	n (see	rchased		cols. 1 thru	
		1.00	2.00	instructions) 3.00	Servi ces 4.00	5.00	5) 6.00	-
	GENERAL SERVICE COST CENTERS		2100			0.00		
0	Capital Related - Bldg. &			0		0	0	1
0	Fixtures Capital Related - Movable			0		4, 327	4, 327	2
.0	Equi pment			0		1, 027	1, 02,	⁻
0	Plant Operation & Maintenance	0	0	0	C	0	0	3
0	Transportation	0	0	207, 578		0 010 149	207, 578	
0	Administrative and General HHA REIMBURSABLE SERVICES	2, 782, 686	0	0	90, 168	8 819, 168	3, 692, 022	5
0	Skilled Nursing Care	0	0	0	0) 0	0	6
0	Physical Therapy	0	0	0	C	0	0	
0	Occupational Therapy	0	0	0	0	0	0	1 U
00 00	Speech Pathology Medical Social Services	0	0	0			0	
00	Home Heal th Aide	0	0	0			0	
00	Supplies (see instructions)	0	0	0	C	33, 724	33, 724	
00	Drugs	0	0	0	C	0	0	
00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0	C	0 0	0	14
00	Home Dialysis Aide Services	0	0	0	0	0	0	15
00	Respiratory Therapy	0	0	0	0	0	0	
00	Private Duty Nursing	0	0	0	C	0 0	0	
00	Clinic	0	0	0	0	0	0	
00 00	Health Promotion Activities Day Care Program	0	0	0			0	
00	Home Delivered Meals Program	0	0				0	
00	Homemaker Service	0	0	0	0	0	0	22
00	All Others (specify)	0	0	0	C	0 0	0	
00	Total (sum of lines 1-23)	2, 782, 686	0	207, 578		8 857, 219	3, 937, 651	24
		Reclassificat ion	Reclassified Trial Balance	Adjustments	Net Expenses for			
			(col. 6 +		Allocation			
			col . 7)		(col. 8 +			
		7.00	8.00	9.00	col. 9) 10.00	-		+
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00			
0	Capital Related - Bldg. &	0	0	0	C)		1
~	Fixtures		4 007	0	4 227	7		
0	Capital Related – Movable Equipment	0	4, 327	0	4, 327			2
0	Plant Operation & Maintenance	0	0	0	C			3
0	Transportati on	0	207, 578					4
0	Administrative and General	-2,036,370	1, 655, 652	-17, 817	1, 637, 835	5		5
0	HHA REIMBURSABLE SERVICES Skilled Nursing Care	1, 151, 197	1, 151, 197	0	1, 151, 197	7		6
0 10	Physical Therapy	609, 130	609, 130		609, 130			0
0	Occupational Therapy	161, 118	161, 118		161, 118			8
0	Speech Pathology	57, 602	57, 602	0	57, 602			9
00	Medical Social Services	5,844	5,844		5,844			10
00 00	Home Health Aide Supplies (see instructions)	51, 479 0	51, 479 33, 724		51, 479 33, 724			11
00	Drugs	0	33,724		33,724			12
	DME	0	0					14
00	HHA NONREI MBURSABLE SERVI CES							
	Home Dialysis Aide Services Respiratory Therapy	0	0	0				15
00	LEAST FATORY INGRADY	0	0	0	0			16
00 00			0			Ó		18
00 00 00	Private Duty Nursing	0	0			1		
00 00		0	0 0	0	0)		19
00 00 00 00	Private Duty Nursing Clinic	0 0 0	0 0 0	0	C C			20
00 00 00 00 00 00 00	Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0 0 0	0 0 0 0	0 0 0	C C C			20 21
00 00 00 00 00 00	Private Duty Nursing Clinic Health Promotion Activities Day Care Program	0 0 0 0 0 0 0	0 0 0 0 0	000000000000000000000000000000000000000				19 20 21 22 23

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable. 5/27/2016 2:52 pm C: \MCRIF32\Floyd2015.mcrx

GENEI . 00 Capi Fi xt 2. 00 Capi Fi xt 2. 00 Capi Equi 3. 00 Pl an 4. 00 Ski I 5. 00 Admi 11. 00 Physic 3. 00 Ski I 3. 00 Supp 3. 00 Drug 4. 00 DME HHA 1 O 5. 00 Home 6. 00 Resp 7. 00 Pri v 8. 00 Cl in Mome 9. 00 Heal 10. 00 Day 11. 00 Home 12. 00 Home 13. 00 Al I 14. 00 Tota	NONREIMBURSABLE SERVICES e Dialysis Aide Services piratory Therapy vate Duty Nursing	Net Expenses for Cost Al location (from Wkst. H, col . 10) 0 0 4, 327 0 207, 578 1, 637, 835 1, 151, 197 609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0 0	Capital Rel Bldgs & Fixtures 1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	HHA CCN:	PI ant Operation & Maintenance	0 109, 643	5/27/2016 2:5 PPS Subtotal (col s. 0-4) 4A. 00 0 1, 642, 162 1, 260, 840 668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	pared: 2 pm 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
.00 Capi Fixt Fixt Equi .00 Plan .00 Plan .00 Tran .00 Admi HHA Admi .00 Skil .00 Skil .00 Skil .00 Skil .00 Skil .00 Skel .00 Spee 0.00 Spee 0.00 Spee 0.00 Medi 1.00 Home 2.00 Supp 3.00 Drug 4.00 Mes 7.00 Priv 8.00 Clin 9.00 Heal 0.00 Day 1.00 Home 1.00 Home 1.00 Home 1.00 All 1.4.00 Tota	ital Related - BIdg. & tures ital Related - Movable ipment nt Operation & Maintenance nsportation inistrative and General <u>REIMBURSABLE SERVICES</u> Iled Nursing Care sical Therapy upational Therapy ech Pathology ical Social Services e Health Aide plies (see instructions) gs <u>NONREIMBURSABLE SERVICES</u> e Dialysis Aide Services piratory Therapy vate Duty Nursing	for Cost Al Location (from Wkst. H, col. 10) 0 4, 327 0 207, 578 1, 637, 835 1, 151, 197 609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0	BI dgs & Fi xtures	ated Costs Movabl e Equi pment 2.00 4,327 0 0 4,327 0 0 0 0 0 0 0 0 0 0 0 0 0	Pl ant Operation & Maintenance	Home Heal th Agency I Transportatio n 4.00 207,578 0 207,578 0 109,643 59,092 15,185 4,158 59 18,941	5/27/2016 2:5 PPS Subtotal (col s. 0-4) 4A. 00 0 1, 642, 162 1, 260, 840 668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	2 pm 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
.00 Capi Fixt Fixt Equi .00 Plan .00 Plan .00 Tran .00 Admi HHA Admi .00 Skil .00 Skil .00 Skil .00 Skil .00 Skil .00 Skel .00 Spee 0.00 Spee 0.00 Spee 0.00 Medi 1.00 Home 2.00 Supp 3.00 Drug 4.00 Mes 7.00 Priv 8.00 Clin 9.00 Heal 0.00 Day 1.00 Home 1.00 Home 1.00 Home 1.00 All 1.4.00 Tota	ital Related - BIdg. & tures ital Related - Movable ipment nt Operation & Maintenance nsportation inistrative and General <u>REIMBURSABLE SERVICES</u> Iled Nursing Care sical Therapy upational Therapy ech Pathology ical Social Services e Health Aide plies (see instructions) gs <u>NONREIMBURSABLE SERVICES</u> e Dialysis Aide Services piratory Therapy vate Duty Nursing	for Cost Al Location (from Wkst. H, col. 10) 0 4, 327 0 207, 578 1, 637, 835 1, 151, 197 609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0	BI dgs & Fi xtures	Movabl e Equi pment 2.00 4,327 0 0 4,327 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Operation & Maintenance	Agency I Transportati o n 4.00 207, 578 0 207, 578 0 109, 643 59, 092 15, 185 4, 158 559 18, 941	PPS Subtotal (col s. 0-4) 4A. 00 0 0 0 1, 642, 162 1, 260, 840 668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
.00 Capi Fixt Fixt Equi .00 Plan .00 Plan .00 Tran .00 Admi HHA Admi .00 Skil .00 Skil .00 Skil .00 Skil .00 Skil .00 Skel .00 Spee 0.00 Spee 0.00 Spee 0.00 Medi 1.00 Home 2.00 Supp 3.00 Drug 4.00 Mes 7.00 Priv 8.00 Clin 9.00 Heal 0.00 Day 1.00 Home 1.00 Home 1.00 Home 1.00 All 1.4.00 Tota	ital Related - BIdg. & tures ital Related - Movable ipment nt Operation & Maintenance nsportation inistrative and General <u>REIMBURSABLE SERVICES</u> Iled Nursing Care sical Therapy upational Therapy ech Pathology ical Social Services e Health Aide plies (see instructions) gs <u>NONREIMBURSABLE SERVICES</u> e Dialysis Aide Services piratory Therapy vate Duty Nursing	for Cost Al Location (from Wkst. H, col. 10) 0 4, 327 0 207, 578 1, 637, 835 1, 151, 197 609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0	BI dgs & Fi xtures	Movabl e Equi pment 2.00 4,327 0 0 4,327 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Operation & Maintenance	Transportati o n 4.00 207,578 0 207,578 0 109,643 59,092 15,185 4,158 559 18,941	(col s. 0-4) 4A. 00 0 0 1, 642, 162 1, 260, 840 668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
.00 Capi Fixt Fixt Equi .00 Plan .00 Plan .00 Tran .00 Admi HHA Admi .00 Skil .00 Skil .00 Skil .00 Skil .00 Skil .00 Skel .00 Spee 0.00 Spee 0.00 Spee 0.00 Medi 1.00 Home 2.00 Supp 3.00 Drug 4.00 Mes 7.00 Priv 8.00 Clin 9.00 Heal 0.00 Day 1.00 Home 1.00 Home 1.00 Home 1.00 All 1.4.00 Tota	ital Related - BIdg. & tures ital Related - Movable ipment nt Operation & Maintenance nsportation inistrative and General <u>REIMBURSABLE SERVICES</u> Iled Nursing Care sical Therapy upational Therapy ech Pathology ical Social Services e Health Aide plies (see instructions) gs <u>NONREIMBURSABLE SERVICES</u> e Dialysis Aide Services piratory Therapy vate Duty Nursing	for Cost Al Location (from Wkst. H, col. 10) 0 4, 327 0 207, 578 1, 637, 835 1, 151, 197 609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0	BI dgs & Fi xtures	Movabl e Equi pment 2.00 4,327 0 0 4,327 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Operation & Maintenance	n 4.00 207,578 0 109,643 59,092 15,185 4,158 559 18,941	(col s. 0-4) 4A. 00 0 0 1, 642, 162 1, 260, 840 668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
.00 Capi Fixt Fixt Equi .00 Plan .00 Plan .00 Tran .00 Admi HHA Admi .00 Skil .00 Skil .00 Skil .00 Skil .00 Skil .00 Skel .00 Spee 0.00 Spee 0.00 Spee 0.00 Medi 1.00 Home 2.00 Supp 3.00 Drug 4.00 Mes 7.00 Priv 8.00 Clin 9.00 Heal 0.00 Day 1.00 Home 1.00 Home 1.00 Home 1.00 All 1.4.00 Tota	ital Related - BIdg. & tures ital Related - Movable ipment nt Operation & Maintenance nsportation inistrative and General <u>REIMBURSABLE SERVICES</u> Iled Nursing Care sical Therapy upational Therapy ech Pathology ical Social Services e Health Aide plies (see instructions) gs <u>NONREIMBURSABLE SERVICES</u> e Dialysis Aide Services piratory Therapy vate Duty Nursing	for Cost Al Location (from Wkst. H, col. 10) 0 4, 327 0 207, 578 1, 637, 835 1, 151, 197 609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0	Fixtures	Equipment 2.00 4,327 0 4,327 0 0 4,327 0 0 0 0 0 0 0 0 0 0 0 0 0	Operation & Maintenance	n 4.00 207,578 0 109,643 59,092 15,185 4,158 559 18,941	(col s. 0-4) 4A. 00 0 0 1, 642, 162 1, 260, 840 668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
.00 Capi Fixt Fixt Equi .00 Plan .00 Plan .00 Tran .00 Admi HHA Admi .00 Skil .00 Skil .00 Skil .00 Skil .00 Skil .00 Skel .00 Spee 0.00 Spee 0.00 Spee 0.00 Medi 1.00 Home 2.00 Supp 3.00 Drug 4.00 Mes 7.00 Priv 8.00 Clin 9.00 Heal 0.00 Day 1.00 Home 1.00 Home 1.00 Home 1.00 All 1.4.00 Tota	ital Related - BIdg. & tures ital Related - Movable ipment nt Operation & Maintenance nsportation inistrative and General <u>REIMBURSABLE SERVICES</u> Iled Nursing Care sical Therapy upational Therapy ech Pathology ical Social Services e Health Aide plies (see instructions) gs <u>NONREIMBURSABLE SERVICES</u> e Dialysis Aide Services piratory Therapy vate Duty Nursing	Al location (from Wkst. H, col. 10) 0 0 4, 327 0 207, 578 1, 637, 835 1, 151, 197 609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0		2.00 4,327 0 4,327 0 4,327 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Mai ntenance 3.00 C C C C C C C C C C C C C	4.00 207,578 0 109,643 59,092 15,185 4,158 559 18,941	4A. 00 0 0 1, 642, 162 1, 260, 840 668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
.00 Capi Fixt Fixt Equi 2.00 Capi Equi 6.00 Plan 6.00 Plan 6.00 Admi HHA Admi HHA Admi 0.00 Skil 7.00 Phys 8.00 Occu 0.00 Spee 0.00 Spee 0.00 Supp 3.00 Drug 4.00 Medi 5.00 Home 6.00 Resp 7.00 Pri v 8.00 Clin 9.00 Heal 10.00 Day 11.00 Home 12.00 All 14.00 Tota	ital Related - BIdg. & tures ital Related - Movable ipment nt Operation & Maintenance nsportation inistrative and General <u>REIMBURSABLE SERVICES</u> Iled Nursing Care sical Therapy upational Therapy ech Pathology ical Social Services e Health Aide plies (see instructions) gs <u>NONREIMBURSABLE SERVICES</u> e Dialysis Aide Services piratory Therapy vate Duty Nursing	(from Wkst. H, col. 10) 0 4, 327 0 207, 578 1, 637, 835 1, 151, 197 609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0 0 0 0 0 0 0 0 0 0 0 0		4, 327 0 0 4, 327 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		207, 578 0 109, 643 59, 092 15, 185 4, 158 59 4, 158 559 18, 941	0 0 1, 642, 162 1, 260, 840 668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
.00 Capi Fixt Fixt Equi 2.00 Capi Equi 6.00 Plan 6.00 Plan 6.00 Admi HHA Admi HHA Admi 0.00 Skil 7.00 Phys 8.00 Occu 0.00 Spee 0.00 Spee 0.00 Supp 3.00 Drug 4.00 Medi 5.00 Home 6.00 Resp 7.00 Pri v 8.00 Clin 9.00 Heal 10.00 Day 11.00 Home 12.00 All 14.00 Tota	ital Related - BIdg. & tures ital Related - Movable ipment nt Operation & Maintenance nsportation inistrative and General <u>REIMBURSABLE SERVICES</u> Iled Nursing Care sical Therapy upational Therapy ech Pathology ical Social Services e Health Aide plies (see instructions) gs <u>NONREIMBURSABLE SERVICES</u> e Dialysis Aide Services piratory Therapy vate Duty Nursing	H, col. 10) 0 0 4, 327 0 207, 578 1, 637, 835 1, 151, 197 609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0		4, 327 0 0 4, 327 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		207, 578 0 109, 643 59, 092 15, 185 4, 158 59 4, 158 559 18, 941	0 0 1, 642, 162 1, 260, 840 668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
.00 Capi Fixt Fixt Equi 2.00 Capi Equi 6.00 Plan 6.00 Plan 6.00 Admi HHA Admi HHA Admi 0.00 Skil 7.00 Phys 8.00 Occu 0.00 Spee 0.00 Spee 0.00 Supp 3.00 Drug 4.00 Medi 5.00 Home 6.00 Resp 7.00 Pri v 8.00 Clin 9.00 Heal 10.00 Day 11.00 Home 12.00 All 14.00 Tota	ital Related - BIdg. & tures ital Related - Movable ipment nt Operation & Maintenance nsportation inistrative and General <u>REIMBURSABLE SERVICES</u> Iled Nursing Care sical Therapy upational Therapy ech Pathology ical Social Services e Health Aide plies (see instructions) gs <u>NONREIMBURSABLE SERVICES</u> e Dialysis Aide Services piratory Therapy vate Duty Nursing	0 4, 327 0 207, 578 1, 637, 835 1, 151, 197 609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0		4, 327 0 0 4, 327 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		207, 578 0 109, 643 59, 092 15, 185 4, 158 59 4, 158 559 18, 941	0 0 1, 642, 162 1, 260, 840 668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
.00 Capi Fixt Fixt Equi 2.00 Capi Equi 6.00 Plan 6.00 Plan 6.00 Admi HHA Admi HHA Admi 0.00 Skil 7.00 Phys 8.00 Occu 0.00 Spee 0.00 Spee 0.00 Supp 3.00 Drug 4.00 Medi 5.00 Home 6.00 Resp 7.00 Pri v 8.00 Clin 9.00 Heal 10.00 Day 11.00 Home 12.00 All 14.00 Tota	ital Related - Bldg. & tures ital Related - Movable ipment nt Operation & Maintenance nsportation inistrative and General <u>REIMBURSABLE SERVICES</u> Iled Nursing Care sical Therapy upational Therapy ech Pathology ical Social Services e Health Aide plies (see instructions) gs <u>NONREIMBURSABLE SERVICES</u> e Dialysis Aide Services piratory Therapy vate Duty Nursing	4, 327 0 207, 578 1, 637, 835 1, 151, 197 609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0		0 0 4,327 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 109, 643 59, 092 0 15, 185 0 4, 158 559 0 18, 941	0 1, 642, 162 1, 260, 840 668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
Fixt 2.00 Capi Equi 2.00 Plan 3.00 Plan 5.00 Admi HHA O 5.00 Skil 7.00 Skil 0.00 Skil 0.00 Skil 0.00 Skil 0.00 Skil 0.00 Medi 1.00 Home 2.00 Supp 3.00 Drug 4.00 Meme 5.00 Home 6.00 Resp 7.00 Priv 8.00 Clin 9.00 Heal 10.00 Day 11.00 Home 12.00 All 14.00 Tota	tures i tal Related - Movable i pment nt Operation & Maintenance nsportation i nistrative and General <u>REIMBURSABLE SERVICES</u> I ed Nursing Care si cal Therapy upational Therapy ech Pathology i cal Social Services e Health Aide plies (see instructions) gs <u>NONREIMBURSABLE SERVICES</u> e Dialysis Aide Services piratory Therapy vate Duty Nursing	4, 327 0 207, 578 1, 637, 835 1, 151, 197 609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0		0 0 4,327 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 109, 643 59, 092 0 15, 185 0 4, 158 559 0 18, 941	0 1, 642, 162 1, 260, 840 668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
Equi 2.00 Plan 3.00 Tran 4.00 Tran 4.00 Skil 5.00 Phys 3.00 Occu 5.00 Medi 1.00 Home 2.00 Supe 0.00 Medi 1.00 Home 3.00 Drug 4.00 Home 5.00 Home 5.00 Home 5.00 Home 2.00 Supp 1.00 Jay 1.00 Home 2.00 Ail 1.00 Home 2.00 Jay 1.00 Tota	i pment nt Operation & Maintenance nsportation inistrative and General REIMBURSABLE SERVICES Iled Nursing Care sical Therapy upational Therapy ech Pathology ical Social Services e Health Aide plies (see instructions) gs NONREIMBURSABLE SERVICES e Dialysis Aide Services piratory Therapy vate Duty Nursing	0 207, 578 1, 637, 835 1, 151, 197 609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0		0 0 4,327 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 109, 643 59, 092 0 15, 185 0 4, 158 559 0 18, 941	0 1, 642, 162 1, 260, 840 668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
a. 00 PI an b. 00 Tran c. 00 Admi HHA Admi HHA Admi b. 00 Ski I c. 00 Ski O c. 00 Spee 0.00 Spee 0.00 Medi 1.00 Home 2.00 Supp 3.00 Drug 4.00 DME HHA State 5.00 Home 6.00 Resp 7.00 Pri v 8.00 Cl in 9.00 Heal 10.00 Day 11.00 Home 12.00 Al I 14.00 Tota	nt Operation & Maintenance nsportation inistrative and General <u>REIMBURSABLE SERVICES</u> Iled Nursing Care sical Therapy upational Therapy ech Pathology ical Social Services te Health Aide plies (see instructions) gs <u>NONREIMBURSABLE SERVICES</u> te Dialysis Aide Services piratory Therapy vate Duty Nursing	1, 637, 835 1, 151, 197 609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0		0 0 0 0 0 0 0 0 0		0 0 109, 643 59, 092 0 15, 185 0 4, 158 559 0 18, 941	1, 260, 840 668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
L.00 Tran Admi HHA HHA No Store Ski V.00 Ski V.00 Spee 0.00 Spee 0.00 Spee 0.00 Medi 1.00 Home 2.00 Supp 3.00 Drug 4.00 DME HHA Solo 5.00 Home 6.00 Resp 7.00 Pri v 8.00 Clin 9.00 Heal 10.00 Day 9.00 Heal 10.00 Day 11.00 Home 12.00 All 14.00 Tota	nsportation inistrative and General <u>REIMBURSABLE SERVICES</u> Iled Nursing Care sical Therapy upational Therapy ech Pathology ical Social Services te Health Aide plies (see instructions) gs <u>NONREIMBURSABLE SERVICES</u> te Dialysis Aide Services piratory Therapy vate Duty Nursing	1, 637, 835 1, 151, 197 609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0		0 0 0 0 0 0 0 0 0		0 0 109, 643 59, 092 0 15, 185 0 4, 158 559 0 18, 941	1, 260, 840 668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
HHA 0.00 Ski I 0.00 Ski I 0.00 Spee 0.00 Spee 0.00 Medi 1.00 Home 2.00 Supp 3.00 Drug 4.00 DME 5.00 Home 6.00 Resp 7.00 Pri v 8.00 Clin 9.00 Heal 0.00 Day 11.00 Home 2.00 Alme 2.00 Day 11.00 Home 2.00 All 2.00 All	REIMBURSABLE SERVICES Iled Nursing Care sical Therapy upational Therapy ech Pathology ical Social Services e Health Aide plies (see instructions) gs NONREIMBURSABLE SERVICES e Dialysis Aide Services piratory Therapy vate Duty Nursing	1, 151, 197 609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0		0 0 0 0 0 0 0 0 0) 109, 643 59, 092 15, 185 4, 158 559 18, 941	1, 260, 840 668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	6.00 7.00 8.00 9.00 10.00 11.00
b. 00 Skil 2.00 Phys 3.00 Occu 0.00 Spee 0.00 Medi 1.00 Home 2.00 Supp 3.00 Drug 4.00 DME HHA 1 5.00 Home 6.00 Resp 7.00 Priv 8.00 Clin 9.00 Heal 10.00 Day 21.00 Home 23.00 All 44.00 Tota	Iled Nursing Care sical Therapy upational Therapy ech Pathology ical Social Services e Health Aide plies (see instructions) gs NONREIMBURSABLE SERVICES e Dialysis Aide Services piratory Therapy vate Duty Nursing	609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0		0 0 0 0 0 0 0 0		59,092 15,185 4,158 559 18,941	668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	7.00 8.00 9.00 10.00 11.00
2.00 Phys 8.00 Occu 9.00 Spee 0.00 Spee 0.00 Medi 1.00 Home 2.00 Supp 3.00 Drug 4.00 HHA 5.00 Home 6.00 Resp 7.00 Priv 8.00 Clin 9.00 Heal 10.00 Day 11.00 Home 12.00 All 14.00 Tota	si cal Therapy upational Therapy ech Pathology ical Social Services e Health Aide plies (see instructions) gs <u>NONREIMBURSABLE SERVICES</u> e Dialysis Aide Services piratory Therapy vate Duty Nursing	609, 130 161, 118 57, 602 5, 844 51, 479 33, 724 0 0		0 0 0 0 0 0 0 0		59,092 15,185 4,158 559 18,941	668, 222 176, 303 61, 760 6, 403 70, 420 33, 724	7.00 8.00 9.00 10.00 11.00
2.00 Spee 0.00 Medi 1.00 Home 2.00 Supp 3.00 Drug 4.00 DME HHA 1 5.00 Home 6.00 Resp 7.00 Priv 8.00 Clin 9.00 Heal 0.00 Day 1.00 Home 2.00 Home 3.00 All 4.00 Tota	ech Pathology ical Social Services e Health Aide plies (see instructions) gs NONREIMBURSABLE SERVICES e Dialysis Aide Services piratory Therapy vate Duty Nursing	57, 602 5, 844 51, 479 33, 724 0 0	i	0 0 0 0 0 0 0		4, 158 559 18, 941	61, 760 6, 403 70, 420 33, 724	9.00 10.00 11.00
0.00 Medi 1.00 Home 2.00 Supp 3.00 DME HHA 5.00 Home 6.00 Resp 7.00 Priv 8.00 Clin 9.00 Heal 0.00 Day 1.00 Home 3.00 All 4.00 Tota	ical Social Services e Health Aide plies (see instructions) gs NONREIMBURSABLE SERVICES e Dialysis Aide Services piratory Therapy vate Duty Nursing	5, 844 51, 479 33, 724 0 0	i	0 0 0 0 0		559 18, 941	6, 403 70, 420 33, 724	10. 00 11. 00
1.00 Home 2.00 Supp 3.00 Drug 4.00 DME 5.00 Home 6.00 Resp 7.00 Pri v 8.00 Clin 9.00 Heat 10.00 Day 11.00 Home 23.00 All 44.00 Tota	e Health Aide plies (see instructions) gs NONREIMBURSABLE SERVICES e Dialysis Aide Services piratory Therapy vate Duty Nursing	51, 479 33, 724 0 0	i	0 0 0 0		18, 941	70, 420 33, 724	11.00
3.00 Drug 4.00 DME HHA 1 5.00 Home 6.00 Priv 8.00 Clin 9.00 Heal 0.00 Day 1.00 Home 2.00 Home 3.00 All 4.00 Tota	gs NONREI MBURSABLE SERVICES e Dialysis Aide Services piratory Therapy vate Duty Nursing	0	i	0 0 0	C	0		12 00
4.00 DME HHA 1 5.00 Home 6.00 Resp 7.00 Priv 8.00 Clin 9.00 Heal 9.00 Heal 0.00 Day 1.00 Home 2.00 Home 3.00 All 4.00 Tota	NONREIMBURSABLE SERVICES e Dialysis Aide Services piratory Therapy vate Duty Nursing	0	i	0 0	C) I		
HHA 5.00 Home 6.00 Resp 7.00 Priv 8.00 Clin 9.00 Heal 0.00 Day 1.00 Home 2.00 Home 3.00 All 4.00 Tota	NONREIMBURSABLE SERVICES e Dialysis Aide Services piratory Therapy vate Duty Nursing	-1	i	0	C	0	0 0	•
5.00 Home 6.00 Resp 7.00 Priv 8.00 Clin 9.00 Heal 0.00 Day 1.00 Home 2.00 Home 3.00 All 4.00 Tota	e Dialysis Aide Services piratory Therapy vate Duty Nursing	0 0	0				0	14.00
7.00 Priv 8.00 Clin 9.00 Heal 0.00 Day 1.00 Home 2.00 Home 3.00 All 4.00 Tota	vate Duty Nursing	0		0	C	0 0	0	
8.00 Clin 9.00 Heal 20.00 Day 1.00 Home 2.00 Home 3.00 All 4.00 Tota			0	0	C	0	0	
9.00 Heal 20.00 Day 21.00 Home 22.00 Home 23.00 All 24.00 Tota	ni c i	0	0	0			0	
21.00 Home 22.00 Home 23.00 All 24.00 Tota	Ith Promotion Activities	0	0	0	C	0	0	19.00
22.00 Home 23.00 All 24.00 Tota	Care Program	0	0	0	C	0	0	
23.00 AII 24.00 Tota	e Delivered Meals Program emaker Service	0	0	0			0	
	Others (specify)	0	0	0	C	0	0	
	al (sum of lines 1-23)	3, 919, 834	0	4, 327	C	207, 578	3, 919, 834	24.00
		Administrativ e & General	Total (cols. 4A + 5)					
		5.00	6.00					
	ERAL SERVICE COST CENTERS							
	ital Related - Bldg. & tures							1.00
	ital Related - Movable							2.00
	ipment							2.00
	nt Operation & Maintenance nsportation							3.00 4.00
. OO Admi	inistrative and General	1, 642, 162						5.00
	REIMBURSABLE SERVICES	000 011	2.1(2.00)					1
	lled Nursing Care sical Therapy	909, 044 481, 777	2, 169, 884 1, 149, 999					6.00 7.00
8. 00 0ccu	upational Therapy	127, 111	303, 414					8.00
.00 Spee	ech Pathology	44, 528	106, 288					9.00
	ical Social Services e Health Aide	4, 616 50, 772	11, 019 121, 192					10.00 11.00
	plies (see instructions)	24, 314	58, 038					12.00
3.00 Drug	gs	0	0					13.00
4.00 DME	NONREI MBURSABLE SERVI CES	0	0					14.00
	e Dialysis Aide Services	0	0					15.00
6.00 Resp	piratory Therapy	0	0					16.00
	vate Duty Nursing	0	0					17.00
8.00 Clin 9.00 Heal	nic Ith Promotion Activities	0	0					18.00 19.00
		0	0					20.00
1.00 Home	Care Program	0	0					21.00
	e Delivered Meals Program		0					22.00 23.00
23.00 ATT 24.00 Tota	ů.	0	01					23.00

COST A	LLOCATION - HHA STATISTICAL BAS	SIS		Provider HHA CCN:	CCN: 150044 157152	Period: From 01/01/2015 To 12/31/2015	Worksheet H-1 Part II Date/Time Pre 5/27/2016 2:5	pared:
						Home Health	PPS	F
						Agency I		
		Capital Rel	ated Costs					
		BIdgs &	Movabl e	Plant	Transportati	o Reconciliatio	Administrativ	1
		Fixtures	Equipment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Maintenance			(ACCUM. COST)	
		. ,	VALUE)	(SQUARE FEET)			`	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS							
. 00	Capital Related - Bldg. &	0				0		1.0
2.00	Fixtures Capital Related - Movable		25, 196			0		2.0
. 00	Equipment		23, 190			0		2.0
. 00	Plant Operation & Maintenance	0	0	0		0		3.0
. 00	Transportation (see	0	0	0	30, 45	56		4.0
	instructions)							
. 00	Administrative and General	0	25, 196	0		0 -1, 642, 162	2, 277, 672	5.0
	HHA REIMBURSABLE SERVICES							
. 00	Skilled Nursing Care	0	0	-			1, 260, 840	
. 00	Physical Therapy	0	0	0	0,0,		668, 222	
. 00	Occupational Therapy	0	0	0	2, 22		176, 303	
. 00 0. 00	Speech Pathology Medical Social Services	0	0	0	61	0 32 0	61, 760 6, 403	
1.00	Home Heal th Aide	0	0		2, 77		70, 420	
2.00	Supplies (see instructions)	0	0	0		0 0	33, 724	
3.00	Drugs	0	0	-		0	00,721	
4.00	DME	0	0	0		0 0	0	
	HHA NONREI MBURSABLE SERVI CES							
5.00	Home Dialysis Aide Services	0	0	-		0 0	0	
6.00	Respiratory Therapy	0	0	0		0 0	0	
7.00	Private Duty Nursing	0	0	0		0 0	0	
8.00	Clinic	0	0	0		0 0	0	
9.00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	
1.00	Home Delivered Meals Program	0	0	0		0 0	0	
2.00	Homemaker Service	0	0			0 0	0	
3.00	All Others (specify)	0	0	0		0 0	0	
4.00	Total (sum of lines 1-23)	Ő	25, 196	0	30, 45	6 -1, 642, 162	2, 277, 672	
5.00	Cost To Be Allocated (per	0	4, 327	0	207, 57		1, 642, 162	
	Worksheet H-1, Part I)							
00 30	Unit Cost Multiplier	0. 000000	0. 171734	0.000000	6. 81566	9	0. 720983	26 (

LLOCATION OF GENERAL SERVICE COSTS	TO TITA COST CEN	TERS			Period: From 01/01/2015	Worksheet H-2 Part I	
			HHA CCN:	157152	To 12/31/2015	Date/Time Pre 5/27/2016 2:5	pared: 2 pm
					Home Health Agency I	PPS	
		CAPI TAL REL	ATED COSTS				
Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL	
	0	1.00	2.00	4.00	4A	5.00	
 .00 Administrative and General .00 Skilled Nursing Care .00 Physical Therapy .00 Occupational Therapy .00 Speech Pathology .00 Medical Social Services .00 Home Health Aide .00 Supplies (see instructions) .00 DME .00 Home Dialysis Aide Services 2.00 Respiratory Therapy 3.00 Private Duty Nursing 4.00 Clinic 5.00 Home Delivered Meals Program 7.00 Home Service 9.00 All Others (specify) 0.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus 	0 2, 169, 884 1, 149, 999 303, 414 106, 288 11, 019 121, 192 58, 038 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			48, 38 25, 60 6, 77 2, 42 24 2, 16	3 2, 218, 267 1 1, 175, 600 2 310, 186 1 108, 709 6 11, 265 4 123, 356 0 58, 038 0 0	5, 821 261, 924 138, 810 36, 626 12, 836 1, 330 14, 565 6, 853 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 18.0 19.0
column 26, line 1, rounded to 6 decimal places. Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	
	REPAI RS 6. 00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	
 .00 Administrative and General .00 Skilled Nursing Care .00 Physical Therapy .00 Occupational Therapy .00 Speech Pathology .00 Medical Social Services .00 Home Health Aide .00 Supplies (see instructions) .00 Drugs .00 Home Dialysis Aide Services .00 Home Dialysis Aide Services .00 Home Dialysis Aide Services .00 Private Duty Nursing .00 Clinic .00 Day Care Program .00 Home Delivered Meals Program .00 Home Delivered Service .00 All Others (specify) .00 Total (sum of lines 1-19) (2) .00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places. 					0 0 0 0	8, 662 11, 352 4, 193 1, 213 492 78 1, 323 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 18.0 19.0

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.
5/27/2016 2:52 pm C: \MCRIF32\Floyd2015.mcrx

	n Financial Systems ATION OF GENERAL SERVICE COSTS ⁻		MEMORIAL HOSP		CCN: 150044	Peri od:	u of Form CMS- Worksheet H-2	
				HHA CCN:	157152	From 01/01/2015 To 12/31/2015	Part I Date/Time Pre 5/27/2016 2:5	epared: 52 pm
						Home Health	PPS	
	Cost Center Description	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	Agency I MEDI CAL	SOCIAL	
	cost center bescription		ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS &	SERVI CE	
		12.00	13.00	14.00	15.00	16.00	17.00	
1. 00 2. 00 3. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00	Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to					0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		2.00 3.00 4.00 5.00 6.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 16.00 17.00 18.00 19.00
	6 decimal places. Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown	Subtotal	Allocated HH A&G (see Par II)			
		24.00	Adjustments 25.00	26.00	27.00	28.00		
1.00 2.00 3.00 5.00 5.00 7.00 7.00 9.00 11.00 11.00 13.00 14.00 15.00 14.00 15.00 16.00 17.00 20.00 21.00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	63, 785 2, 491, 543 1, 318, 603 348, 025 122, 037 12, 673 139, 244 64, 891 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	63, 785 2, 491, 543 1, 318, 603 348, 025 122, 037 12, 673 139, 244 64, 891 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	35, 34 18, 70 4, 93 1, 73 18 1, 97 92	$\begin{array}{cccccccccccccccccccccccccccccccccccc$		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.
5/27/2016 2:52 pm C: \MCRIF32\Floyd2015.mcrx

Heal th	Financial Systems	FLOYD	MEMORIAL HOSP	ITAL & HEALTH	SVS		In Lie	u of Form CMS-2	2552-10
ALLOCA BASI S	TION OF GENERAL SERVICE COSTS	TO HHA COST CEN	ITERS STATISTIC	AL Provider HHA CCN:	CCN: 150044 157152		riod: om 01/01/2015 12/31/2015	Date/Time Pre	pared:
						-	Home Health	5/27/2016 2: 5 PPS	2 pm
						·	Agency I	115	
		CAPI TAL REL	ATED COSTS						
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliati		MINI STRATI V	MAINTENANCE &	
	cost center bescription	(SQUARE FEET)	(DOLLAR	BENEFITS	n		E & GENERAL	REPAI RS	
			VALUE)	DEPARTMENT		((ACCUM. COST)	(SQUARE FEET)	
				(GROSS SALARI ES)					
		1.00	2.00	4.00	5A		5.00	6.00	
1.00	Administrative and General	0	25, 196			0	49, 302	0	1.00
2.00	Skilled Nursing Care	0	0			0	2, 218, 267	0	2.00
3.00	Physical Therapy	0	0	609, 130		0	1, 175, 600	0	3.00
4.00 5.00	Occupational Therapy Speech Pathology	0	0	161, 118 57, 602		0	310, 186 108, 709	0	4.00 5.00
6.00	Medical Social Services	0	0	5, 844		o	11, 265	0	6.00
7.00	Home Health Aide	0	0	51, 479		0	123, 356	0	7.00
8.00	Supplies (see instructions)	0	0	0		0	58, 038	0	8.00
9.00	Drugs	0	0	0		0	0	0	9.00
10. 00 11. 00	DME Home Dialysis Aide Services	0	0			0	0	0	10. 00 11. 00
12.00	Respi ratory Therapy	0	0			0	0	0	12.00
13.00	Private Duty Nursing	0	0			0	0	0	13.00
14.00	Clinic	0	0	0		0	0	0	14.00
15.00	Health Promotion Activities	0	0	0		0	0	0	15.00
16.00	Day Care Program	0	0	0		0	0	0	16.00
17.00 18.00	Home Delivered Meals Program Homemaker Service	0	0			0	0	0	17.00 18.00
19.00	All Others (specify)	0	0			0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	25, 196	2, 782, 686			4, 054, 723	0	20.00
21.00	Total cost to be allocated	0	17, 935				478, 765	0	21.00
22.00	Unit cost multiplier	0.000000					0. 118076		22.00
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY (MEALS		CAFETERI A (PRODUCTI VE	MAI NTENANCE OF PERSONNEL	
		(SQUARE FEET)	(POUNDS OF		SERVED)		HOURS)	(NUMBER	
		· · · · ·	LAUNDRY)					HOUSED)	
1 00		7.00	8.00	9.00	10.00	0	11.00	12.00	1 00
1.00 2.00	Administrative and General Skilled Nursing Care	0	0			0	26, 603 34, 869	0	1.00 2.00
3.00	Physical Therapy	0	0			0	12, 877	0	3.00
4.00	Occupational Therapy	0	0	0		0	3, 724	0	4.00
5.00	Speech Pathology	0	0	0		0	1, 510	0	5.00
6.00	Medical Social Services	0	0	0		0	239	0	6.00
7.00 8.00	Home Health Aide Supplies (see instructions)	0	0			0	4,064	0	7.00 8.00
9.00	Drugs	0	0			0	0	0	9.00
10.00	DME	0	0	0		0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0		0	0	0	11.00
12.00	Respiratory Therapy	0	0	0		0	0	0	
13.00	Private Duty Nursing Clinic	0	0			0	0	0	
14.00 15.00	Health Promotion Activities	0	0			0	0	0	14.00 15.00
16.00	Day Care Program	0	0			0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0		0	0	0	17.00
18.00	Homemaker Service	0	0	0		0	0	0	18.00
19.00	All Others (specify)	0	0			0	0	0	19.00
20.00	Total (sum of lines 1-19) Total cost to be allocated	0				0	83, 886 27, 313	0	20. 00 21. 00
	Unit cost multiplier	0. 000000	0. 000000	0. 000000	0.0000	00	0. 325597	0. 000000	
						'	1		

Heal th	Financial Systems	FLOYD	MEMORIAL HOSP	I TAL	& HEALTH	SVS		In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS STATISTIC	AL	Provi der	CCN: 150044		eriod:	Worksheet H-2	
BASI S					HHA CCN:	157152		rom 01/01/2015 0 12/31/2015		narod
					TITA CON.	157152		12/31/2015	5/27/2016 2:5	
								Home Health	PPS	
								Agency I		
	Cost Center Description	NURSI NG	CENTRAL	PI	HARMACY	MEDI CAL		SOCI AL		
		ADMI NI STRATI O	SERVICES &		COSTED	RECORDS &		SERVI CE		
		N	SUPPLY	RI	EQUIS.)	LI BRARY		(TIME SPENT)		
		(DI RECT	(COSTED			(TIME SPENT)			
		NRSING HRS)	REQUIS.)							
		13.00	14.00		15.00	16.00		17.00		
1.00	Administrative and General	0	0		0		0	0		1.00
2.00	Skilled Nursing Care	0	0		0		0	0		2.00
3.00	Physical Therapy	0	0		0		0	0		3.00
4.00	Occupational Therapy	0	0		0		0	0		4.00
5.00	Speech Pathology	0	0		0		0	0		5.00
6.00	Medical Social Services	0	0		0		0	0		6.00
7.00	Home Health Aide	0	0		0		0	0		7.00
8.00	Supplies (see instructions)	0	0		0		0	0		8.00
9.00	Drugs	0	0		0		0	0		9.00
10.00	DME	0	0		0		0	0		10.00
11.00	Home Dialysis Aide Services	0	0		0		0	0		11.00
12.00	Respiratory Therapy	0	0		0		0	0		12.00
13.00	Private Duty Nursing	0	0		0		0	0		13.00
14.00	Clinic	0	0		0		0	0		14.00
15.00	Health Promotion Activities	0	0		0		0	0		15.00
16.00	Day Care Program	0	0		0		0	0		16.00
17.00	Home Delivered Meals Program	0	0		0		0	0		17.00
18.00	Homemaker Service	0	0		0		0	0		18.00
19.00	All Others (specify)	0	0		0		0	0		19.00
20.00	Total (sum of lines 1-19)	0	0		0		0	0		20.00
21.00	Total cost to be allocated	0	0		0		0	0		21.00
22.00	Unit cost multiplier	0. 000000	0. 000000		0.000000	0.0000	00	0. 000000		22.00

	Financial Systems		MEMORIAL HOSP				u of Form CMS-2	2552-1
APPORT	IONMENT OF PATIENT SERVICE COST	ſS		Provider HHA CCN:	CCN: 150044 157152	Period: From 01/01/2015 To 12/31/2015	Worksheet H-3 Part I Date/Time Prep	pared [.]
					e XVIII	Home Health	5/27/2016 2: 52 PPS	
				11 11	e XVIII	Agency I	PP5	
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	Costs (from Wkst. H-2,	Ancillary Costs (from	Costs (col s 1 + 2)	•	Per Visit (col. 3 ÷	
		20, 11110	Part I)	Part II)			col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE I	PROGRAM COST, A	AGGREGATE OF T	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	
	COST LIMITATION Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	2, 526, 883		2, 526, 8	83 16, 087	157.08	1.0
2.00	Physical Therapy	3.00	1, 337, 306		1, 337, 3			2.0
3.00	Occupational Therapy	4.00	352, 961	(352, 9	61 2, 228	158. 42	3.0
4.00	Speech Pathology	5.00	123, 768		123, 7			4.00
5.00	Medical Social Services	6.00	12, 853		12,8		156.74	5.00
5.00 7.00	Home Health Aide Total (sum of lines 1-6)	7.00	141, 219 4, 494, 990		141, 2 4, 494, 9		50. 82	6.0 7.0
7.00	Total (suil of Times 1-6)		4, 494, 990		Program Visi			7.00
	Cost Contor Description	Coot Limito	CDCA No (1)	Dort A		art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to Deductibles		
					Deducti bl es			
					Coi nsurance	2		
		0	1.00	2.00	3.00	4.00	5.00	
3. 00	Limitation Cost Computation Skilled Nursing Care		31140		1,0	00		8.00
3. 00 3. 01	Skilled Nursing Care		50031			51		8.0
3. 02	Skilled Nursing Care		50033		8,9			8.0
3. 03	Skilled Nursing Care		50040			30		8.0
3. 04	Skilled Nursing Care		99915			57		8.0
9.00	Physical Therapy		31140	(55		9.0
9.01 9.02	Physical Therapy		50031 50033) 1) 4,7	60		9.0 9.0
7.02 7.03	Physical Therapy Physical Therapy		50033			98		9.0
7.03 7.04	Physical Therapy		99915			11		9.0
0.00	Occupational Therapy		31140			84		10.0
0. 01	Occupational Therapy		50031			51		10.0
0. 02	Occupational Therapy		50033		1,3			10. 0
0.03	Occupational Therapy		50040			28		10.0
0.04	Occupational Therapy Speech Pathology		99915 31140			1 42		10. 0 11. 0
11.00	Speech Pathology		50031			42 24		11.0
1.02	Speech Pathology		50033			30		11.0
1.03	Speech Pathology		50040			1		11.0
11.04	Speech Pathology		99915			0		11.0
	Medical Social Services		31140			14		12.0
12.01	Medical Social Services		50031			3		12.0
12.02 12.03	Medical Social Services Medical Social Services		50033 50040			44 7		12.0 12.0
2.03	Medical Social Services		99915			0		12.0
13.00	Home Heal th Ai de		31140			33		13.0
13.00	Home Heal th Ai de		50031			42		13.0
13.02	Home Health Aide		50033		2,1			13.0
13.03	Home Health Aide		50040			34		13.0
13.04	Home Health Aide		99915	(0		13.0
14.00	Total (sum of lines 8-13)				20, 4	~ ~		14.00

Heal th	Financial Systems	FLOYE	MEMORIAL HOSF	NITAL & HEALTH	SVS	In Lie	u of Form CMS-2	2552-10
	TIONMENT OF PATIENT SERVICE COST					Peri od:	Worksheet H-3	
				HHA CCN:	157152	From 01/01/2015	Part I Date/Time Pre	pared:
				Ti tl	e XVIII	Home Health	5/27/2016 2:5 PPS	2 pm
					C AWITI	Agency I	115	
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA	Total Charges	Ratio (col. 3	
		H-2 Part I,	Costs (from	Ancillary	Costs (cols.		÷ col. 4)	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)	Record)		
			Part I)	Part II)				
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Comput							
15.00	Cost of Medical Supplies	8.00						
16.00	Cost of Drugs	9.00			Cost of	0 0	0.00000	16.00
			Program Visits		Services			
			Par	t B	Jervices	Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST,	AGGREGATE OF T	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	
1 00	Cost Per Visit Computation		40 700		1	0 1 (04 6)		1 00
1.00	Skilled Nursing Care	0				0 1, 684, 369		1.00
2.00	Physical Therapy	0				0 821, 227		2.00
3.00 4.00	Occupational Therapy Speech Pathology	0				0 246, 660 0 80, 551		3.00 4.00
4.00 5.00	Medical Social Services					0 10, 658		4.00 5.00
6.00	Home Heal th Ai de					0 122, 984		6.00
7.00	Total (sum of lines 1-6)					0 2, 966, 449		7.00
7.00	Cost Center Description		20,407			2,700,447		7.00
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00								
	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care Skilled Nursing Care							8. 00 8. 01
8. 01 8. 02	Skilled Nursing Care Skilled Nursing Care							8. 01 8. 02
8. 01 8. 02 8. 03	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care							8. 01 8. 02 8. 03
8. 01 8. 02 8. 03 8. 04	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care							8. 01 8. 02 8. 03 8. 04
8. 01 8. 02 8. 03 8. 04 9. 00	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy							8. 01 8. 02 8. 03 8. 04 9. 00
8. 01 8. 02 8. 03 8. 04 9. 00 9. 01	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy							8.01 8.02 8.03 8.04 9.00 9.01
8.01 8.02 8.03 8.04 9.00 9.01 9.02	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy							8.01 8.02 8.03 8.04 9.00 9.01 9.02
8. 01 8. 02 8. 03 8. 04 9. 00 9. 01 9. 02 9. 03	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy							8.01 8.02 8.03 8.04 9.00 9.01 9.02 9.03
8. 01 8. 02 8. 03 8. 04 9. 00 9. 01 9. 02 9. 03 9. 04	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Physical Therapy							8. 01 8. 02 8. 03 8. 04 9. 00 9. 01 9. 02 9. 03 9. 04
8. 01 8. 02 8. 03 8. 04 9. 00 9. 01 9. 02 9. 03 9. 04 10. 00	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy							8.01 8.02 8.03 8.04 9.00 9.01 9.02 9.03 9.04 10.00
8. 01 8. 02 8. 03 8. 04 9. 00 9. 01 9. 02 9. 03 9. 04 10. 00 10. 01	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy							8.01 8.02 8.03 8.04 9.00 9.01 9.02 9.03 9.04 10.00 10.01
$\begin{array}{c} 8.\ 01\\ 8.\ 02\\ 8.\ 03\\ 8.\ 04\\ 9.\ 00\\ 9.\ 01\\ 9.\ 02\\ 9.\ 03\\ 9.\ 04\\ 10.\ 00\\ 10.\ 01\\ 10.\ 02\\ \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy							8.01 8.02 8.03 8.04 9.00 9.01 9.02 9.03 9.04 10.00 10.01 10.02
$\begin{array}{c} 8.\ 01\\ 8.\ 02\\ 8.\ 03\\ 8.\ 04\\ 9.\ 00\\ 9.\ 01\\ 9.\ 02\\ 9.\ 03\\ 9.\ 04\\ 10.\ 00\\ 10.\ 01\\ 10.\ 02\\ 10.\ 03\\ \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy							8.01 8.02 8.03 8.04 9.00 9.01 9.02 9.03 9.04 10.00 10.01 10.02 10.03
$\begin{array}{c} 8.\ 01\\ 8.\ 02\\ 8.\ 03\\ 8.\ 04\\ 9.\ 00\\ 9.\ 01\\ 9.\ 02\\ 9.\ 03\\ 9.\ 04\\ 10.\ 00\\ 10.\ 01\\ 10.\ 02\\ 10.\ 03\\ 10.\ 04\\ \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy							$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \end{array}$
$\begin{array}{c} 8.\ 01\\ 8.\ 02\\ 8.\ 03\\ 8.\ 04\\ 9.\ 00\\ 9.\ 01\\ 9.\ 02\\ 9.\ 03\\ 9.\ 04\\ 10.\ 00\\ 10.\ 01\\ 10.\ 02\\ 10.\ 03\\ \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy							8.01 8.02 8.03 8.04 9.00 9.01 9.02 9.03 9.04 10.00 10.01 10.02 10.03
$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology							$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \end{array}$
$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology							$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \end{array}$
$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology							$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \end{array}$
$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology							$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \end{array}$
$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services							$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \end{array}$
$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \\ 12. \ 02 \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services							$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \\ 12. \ 02 \end{array}$
$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 02 \\ 12. \ 03 \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services							$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \\ 12. \ 02 \\ 12. \ 03 \end{array}$
$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \\ 22. \ 03 \\ 12. \ 04 \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services							$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \\ 12. \ 02 \\ 12. \ 03 \\ 12. \ 04 \end{array}$
$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \\ 12. \ 02 \\ 12. \ 01 \\ 12. \ 02 \\ 12. \ 04 \\ 13. \ 00 \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Home Health Aide							$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \\ 12. \ 02 \\ 12. \ 03 \\ 12. \ 04 \\ 13. \ 00 \end{array}$
$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \\ 12. \ 02 \\ 12. \ 03 \\ 12. \ 03 \\ 12. \ 03 \\ 13. \ 00 \\ 13. \ 01 \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services							$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \\ 12. \ 02 \\ 12. \ 03 \\ 12. \ 04 \\ 13. \ 00 \\ 13. \ 01 \end{array}$
$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \\ 12. \ 02 \\ 12. \ 03 \\ 12. \ 04 \\ 13. \ 00 \\ 13. \ 01 \\ 13. \ 02 \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Home Heal th Aide Home Heal th Aide							$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \\ 12. \ 02 \\ 12. \ 03 \\ 12. \ 04 \\ 13. \ 00 \\ 13. \ 01 \\ 13. \ 02 \end{array}$
$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \\ 12. \ 02 \\ 12. \ 03 \\ 12. \ 04 \\ 13. \ 00 \\ 13. \ 01 \\ 13. \ 02 \\ 13. \ 03 \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Heal th Aide Home Heal th Aide Home Heal th Aide							$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \\ 12. \ 02 \\ 12. \ 03 \\ 12. \ 04 \\ 13. \ 00 \\ 13. \ 03 \\ 13. \ 03 \end{array}$
$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \\ 12. \ 02 \\ 12. \ 03 \\ 12. \ 04 \\ 13. \ 00 \\ 13. \ 01 \\ 13. \ 02 \\ 13. \ 03 \\ 13. \ 04 \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Home Heal th Aide Home Heal th Aide							$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 8. \ 03 \\ 8. \ 04 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 9. \ 03 \\ 9. \ 04 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 10. \ 03 \\ 10. \ 04 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 11. \ 03 \\ 11. \ 04 \\ 12. \ 00 \\ 12. \ 01 \\ 12. \ 02 \\ 12. \ 03 \\ 12. \ 04 \\ 13. \ 00 \\ 13. \ 01 \\ 13. \ 02 \end{array}$

PORT	ONMENT OF PATIENT SERVICE COST	rs		Provi der HHA CCN:	CCN: 150044 157152	Period: From 01/01/2015 To 12/31/2015	Worksheet H-3 Part I Date/Time Pre 5/27/2016 2:5	pared
				Titl	e XVIII	Home Health	PPS	
		Progr	am Covered Cha	arges	Cost of	Agency I		
					Servi ces			
				t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to Deductibles &	Deductibles & Coinsurance		to Deductibles &	Deductibles & Coinsurance	
			Coi nsurance	cornsul ance		Coi nsurance		
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Comput			-				
	Cost of Medical Supplies	0				0 62, 965		
. 00	Cost of Drugs	T 1 1 D	0	0		0	0	16.0
	Cost Center Description	Total Program Cost (sum of						
		col s. 9-10)						
		12.00						1
	PART I - COMPUTATION OF LESSER		PROGRAM COST,	AGGREGATE OF TI	HE PROGRAM L	IMITATION COST, C	R BENEFICIARY	
	COST LIMITATION							
	Cost Per Visit Computation							
	Skilled Nursing Care	1, 684, 369						1.
00	Physical Therapy	821, 227						2.
00 00	Occupational Therapy	246, 660 80, 551						3. 4.
00	Speech Pathology Medical Social Services	10, 658						4. 5.
00	Home Heal th Ai de	122, 984						6.
00	Total (sum of lines 1-6)	2, 966, 449						7.
1	Cost Center Description							
		12.00						
	Limitation Cost Computation							
00	Skilled Nursing Care							8.
01	Skilled Nursing Care							8.
02	Skilled Nursing Care							8. 8.
03 04	Skilled Nursing Care Skilled Nursing Care							8.
00	Physical Therapy							9.
01	Physical Therapy							9.
02	Physical Therapy							9.
03	Physical Therapy							9.
)4	Physical Therapy							9.
	Occupational Therapy							10.
	Occupational Therapy							10.
	Occupational Therapy							10. 10.
	Occupational Therapy Occupational Therapy							10.
	Speech Pathology							11.
01	Speech Pathology							11.
02	Speech Pathology							11.
03	Speech Pathology							11.
04	Speech Pathology							11.
	Medical Social Services							12.
	Medical Social Services							12.
	Medical Social Services							12.
03 04	Medical Social Services Medical Social Services							12. 12.
	Home Health Aide							12.
	Home Health Aide							13.
~ 1	Home Heal th Ai de							13.
02								
	Home Health Aide							13.
03	Home Health Aide Home Health Aide							13. 13.

Health Financial Systems	FLOYD	MEMORIAL HOSP	ITAL & HEALTH	SVS	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 150044	Peri od:	Worksheet H-3	
			HHA CCN:	157152	From 01/01/2015 To 12/31/2015		nared
			TITIA CON.	137 132	10 12/31/2013	5/27/2016 2:5	
			Ti tl	e XVIII	Home Health	PPS	
					Agency I		
Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST	F OF HHA SERVI	CES FURNI SHED	BY SHARED HOSP	ITAL DEPARTME	INTS		
1.00 Physical Therapy	66.00	0. 212414	0		0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67.00	0. 000000	0		0 col. 2, line 3	. 00	2.00
3.00 Speech Pathology	68.00	0. 319725	0		0 col. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	71.00	0. 637169	0		0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 228482	0		0 col. 2, line 1	6. 00	5.00

	Financial Systems FLOYD MEMORIAL HOSPITAL TION OF HHA REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150044	Period: From 01/01/2	0015	Worksheet H-4 Part I-II	ļ
		HHA CCN:	157152				
		Ti tl	e XVIII	Home Healt Agency I		PPS	
					Par		
			Part A	Not Subjecto		Subject to Deductibles &	
				Deductible: Coinsuran		Coi nsurance	
ī	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOM	ARY CHARGE	1.00 FS	2.00		3.00	
-	Reasonable Cost of Part A & Part B Services						1
	Reasonable cost of services (see instructions)			0	0	0	1
00 [Total charges			0	0	0	2
	Customary Charges		1		-		Ι.
	Amount actually collected from patients liable for payment for	servi ces		0	0	0	3
	on a charge basis (from your records) Amount that would have been realized from patients liable for p	avment		0	0	0	4
	for services on a charge basis had such payment been made in ac			-	9	0	4
	with 42 CFR §413.13(b)						
	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	00 0.000	0000	0.000000	
	Total customary charges (see instructions)			0	0	0	
	Excess of total customary charges over total reasonable cost (c	omplete		0	0	0	7
0	only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete only I average line ()	ifline		0	0	0	8
	1 exceeds line 6) Primary payer amounts			0	0	0	
				Part A		Part B	
				Servi ces	5	Servi ces	
				1.00		2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions)				0	0	10
	Total PPS Reimbursement - Full Episodes without Outliers				0	3, 367, 827	
	Total PPS Reimbursement - Full Episodes with Outliers				0	18, 814	
	Total PPS Reimbursement - LUPA Episodes				0	59, 752	
00	Total PPS Reimbursement - PEP Episodes				0	23, 143	14
	Total PPS Outlier Reimbursement - Full Episodes with Outliers				0	4, 534	
	Total PPS Outlier Reimbursement - PEP Episodes				0	0	
	Total Other Payments DME Payments				0	-8, 866	
00	Oxygen Payments				0	0	
	Prosthetic and Orthotic Payments				0	0	
	Part B deductibles billed to Medicare patients (exclude coinsur	ance)				0	2
00	Subtotal (sum of lines 10 thru 20 minus line 21)				0	3, 465, 204	22
	Excess reasonable cost (from line 8)				0	0	
00					0	3, 465, 204	
00 2 00 1 00 2	Subtotal (line 22 minus line 23)						2!
00 00 00 00 00 00 00 00 00 00 00 00 00	Coinsurance billed to program patients (from your records)				_	0 3 465 204	1 2
00 00 00 00 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)				0	3, 465, 204	
00 00 00 00 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	tructions)		0	-	27
00 00 00 00 00 00 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25))		0	-	27 28
00 00 00 00 00 00 00 00 00 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs – current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	27))		_	3, 465, 204 3, 465, 204 0	27 28 29 30
00 50	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	27))		_	3, 465, 204 3, 465, 204 0 0	27 28 29 30 30
00 3 00 3 00 3 00 3 00 3 00 3 00 3 00 3 00 3 00 3 00 3 00 3 00 3 00 3 00 3 00 3	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs – current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions)	27))		_	3, 465, 204 3, 465, 204 0 3, 465, 204	27 28 29 30 30 31
.00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00 .00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions)	27))		_	3, 465, 204 3, 465, 204 0 3, 465, 204 69, 305	27 28 29 30 30 31 31
. 00 . 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)	27))		_	3, 465, 204 3, 465, 204 0 3, 465, 204 69, 305 3, 395, 899	27 28 29 30 30 31 31 31
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions)	27))		_	3, 465, 204 3, 465, 204 0 3, 465, 204 69, 305	27 28 29 30 30 31 31 31 32 33

	SIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED AM BENEFICIARIES		ovi der IA CCN:	CCN: 150044 157152	Period: From 01/01/2015 To 12/31/2015		
					Home Health	PPS	
		I	npati en	t Part A	Agency I Pa	rt B	
	-	mm/dd	/vvvv	Amount	mm/dd/yyyy	Amount	
		1.		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				0 0	3, 395, 899 0	1. (2. (
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3. (
01	Program to Provider				0	0	3. (
01 02 03 04 05					0 0 0 0		3. (3. (3. (3. (3. (
	Provider to Program						
50 51 52 53 54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)				0 0 0 0 0 0	0 0 0 0 0	3. 3. 3. 3. 3. 3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR				0	3, 395, 899	4.
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider						5.
01					0	0	5.
02 03					0 0	0 0	5. 5.
50	Provider to Program		- 1		0	0	5.
50 51 52 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines				0	0	5. 5. 5.
00	5.50-5.98) Determined net settlement amount (balance due) based on						6.
01 02	the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM				0	0	6. 6.
00	Total Medicare program liability (see instructions)				0 Contractor	3, 395, 899 NPR Date	7.
			0		<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	

ALCULATION OF CAPITAL PAYMENT		Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Pre 5/27/2016 2:5	
	Title XVIII	Hospi tal	PPS	z pili
			1.00	
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
00 Capital DRG other than outlier			4, 257, 520	1.0
01 Model 4 BPCI Capital DRG other than outlier			0	1.
00 Capital DRG outlier payments			36, 060	
01 Model 4 BPCI Capital DRG outlier payments			0	1
00 Total inpatient days divided by number of days in t	the cost reporting period (see inst	ructions)	154.09	
00 Number of interns & residents (see instructions)			0.00	
00 Indirect medical education percentage (see instruct			0.00	
00 Indirect medical education adjustment (multiply lir 1.01) (see instructions)			0	6.
00 Percentage of SSI recipient patient days to Medicar 30) (see instructions)	re Part A patient days (Worksheet E,	part A line	5.00	7.
00 Percentage of Medicaid patient days to total days ((see instructions)		14. 51	
00 Sum of lines 7 and 8			19. 51	
.00 Allowable disproportionate share percentage (see ir			4.03	
.00 Disproportionate share adjustment (see instructions			171, 578	
.00 Total prospective capital payments (see instruction	าร)		4, 465, 158	12.
		-	1.00	
PART II - PAYMENT UNDER REASONABLE COST 00 Program inpatient routine capital cost (see instruc			0	1.
00 Program inpatient routine capital cost (see instruction of the program inpatient ancillary capital cost (see instruction)			0	
00 Total inpatient program capital cost (see fish			0	
00 Capital cost payment factor (see instructions)	The 2)		0	4.
00 Total inpatient program capital cost (line 3 x line	- 1)		0	
oo Tiotai Thpatrent program capital cost (The 5 x The	5 4)		0	5.
		-	1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00 Program inpatient capital costs (see instructions)			0	
00 Program inpatient capital costs for extraordinary of			0	2.
00 Net program inpatient capital costs (line 1 minus l	ine z)		0 0.00	
00 Applicable exception percentage (see instructions) 00 Capital cost for comparison to payments (line 3 x l	ing ()		0.00	
00 Capital cost for comparison to payments (line 3 x l 00 Percentage adjustment for extraordinary circumstanc			0.00	
00 Adjustment to capital minimum payment level for ext		line 6)	0.00	
00 Capital minimum payment level (line 5 plus line 7)			0	
00 Current year capital payments (from Part I, line 12	2 as applicable)		0	
.00 Current year comparison of capital minimum payment		ess line 9)	0	1
.00 Carryover of accumulated capital minimum payment (Worksheet L, Part III, line 14)			0	
	capital payments (line 10 plus line	e 11)	0	12.
00 Net comparison of capital minimum payment level to	1 1 2 1		0	
			0	
.00 Current year exception payment (if line 12 is posit		ollowing periodl		
 00 Current year exception payment (if line 12 is posit 00 Carryover of accumulated capital minimum payment le 	evel over capital payment for the for	ollowing period	0	14.
3.00 Current year exception payment (if line 12 is posit 4.00 Carryover of accumulated capital minimum payment le (if line 12 is negative, enter the amount on this l	evel over capital payment for the for the for	ollowing period	-	
8.00 Current year exception payment (if line 12 is posit 9.00 Carryover of accumulated capital minimum payment le	evel over capital payment for the fo line) nt (see instructions)	ollowing period	0 0	15