## PART II - CERTIFICATION

(4) Reopened(5) Amended

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

## CERTIFICATION BY 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 THOMAS H BOYD CRITICAL ACC HOSPITAL (141300) for the cost reporting period beginning 09/01/2014 and ending 08/31/2015 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.

Officer or Administrator of Provider(s)

Title

	·		Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-128, 402	168, 524	-26, 229	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
4.00	SUBPROVI DER I	0	0	0		0	4. 00
5.00	Swing bed - SNF	0	-18, 047	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
8.00	NURSING FACILITY	0				0	8. 00
10.00	RURAL HEALTH CLINIC I	0		-9, 177		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200.00	Total	0	-146, 449		-26, 229		200. 00

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

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 141300 Peri od: Worksheet S-2 From 09/01/2014 Part I Date/Time Prepared: 08/31/2015 1/28/2016 9:46 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 800 SCHOOL STREET 1.00 PO Box: 1.00 2.00 City: CARROLLTON State: IL Zip Code: 62016 County: GREENE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 THOMAS H BOYD CRITICAL 141300 99914 07/12/1999 Ν 0 0 3.00 ACC HOSPITAL Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovi der - (Other) 6.00 Swing Beds - SNF THOMAS H BOYD CRITICAL 147300 99914 07/12/1999 N 0 7 00 7.00 N ACC SWING BED 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC GREENE COUNTY RHC 143403 99914 06/22/1995 N 0 Ν 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospital - Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 09/01/2014 08/31/2015 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Ν Ν 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.

22.01 Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 Ν Ν period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be N Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 N 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 O O 0 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4. Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 ol 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ГА	Provi der (	F	eriod: rom 09/01/ o 08/31/		Workshe Part I Date/Ti 1/28/20	me Pre	pared:
					Urban/Rui				
26. 00	Enter your standard geographic classification (not wa	ne) sta	atus at the begi	inning of the	1.00	2	2.0	)0	26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa	rural. ge) sta	atus at the end	of the cost		2			27. 00
35. 00	reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifilf this is a sole community hospital (SCH), enter the	cati on	in column 2.			0			35. 00
	effect in the cost reporting period.	Begi nni	na:	Endi	na.				
					1.00		2. (		
36. 00			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.	the nu	•			0			37. 00
38. 00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.  If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status								38. 00
	enter subsequent dates.				Y/N		Y/		
39. 00	Does this facility qualify for the innatient hospital	navmer	nt adiustment fo	ar Low volume	1. 00 N	1	2. (		39. 00
37.00	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req	)? Ent∈ uireme⊓	er in column 1 nts in accordan	"Y" for yes ce with 42					37.00
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	adj us <sup>.</sup> er 1. l	tment? Enter "Y' Enter "Y" for ye	for yes or	N		N		40. 00
	jilo III column 2, for discharges on or after october 1.	(see i	instructions)			V	XVIII	XI X	
	0.000					1. 00	2.00	3.00	
45. 00	Does this facility qualify and receive Capital paymen	t for o	di sproporti onato	e share in ac	cordance	N	N	N	45. 00
46. 00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst					N	N	N	46. 00
47. 00 48. 00	Is the facility electing full federal capital payment					N N	N N	N N	47. 00 48. 00
56. 00		approve	ed GME programs	? Enter "Y"	for yes	N			56. 00
57. 00	or "N" for no.  If line 56 is yes, is this the first cost reporting p  GME programs trained at this facility? Enter "Y" for  is "Y" did residents start training in the first mont  for yes or "N" for no in column 2. If column 2 is "Y  "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes on h of th ", comp	r "N" for no in his cost reporti plete Worksheet	column 1. If ing period?	column 1 Enter "Y"				57.00
58. 00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	ursemei	nt for physicia	ns' services a	as	N			58. 00
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health					N N			59. 00 60. 00
	provider-operated criteria under §413.85? Enter "Y"					IN			80.00
		Y/N	IME	Direct GME	IME		Di rect	t GME	
		1. 00	2. 00	3. 00	4.00	)	5. (	00	
61. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					0.00		0. 00	61.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.0	d				61. 01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.0	o				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		0.00	0.0	0				61. 03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	o				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		0.00	0.0	o				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		0.00	0. 0	0				61.06
	care or general surgery. (see instructions)		I I		1				I

Health Financial Systems	THOMAS H BOYI	<u>D CRITICA</u> L	ACC HOSPI	TAL	<u> </u>	u of Form CMS-2	<u> 2552-1</u> 0
HOSPITAL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	TA	Provi der	F	eriod: rom 09/01/2014 o 08/31/2015	Worksheet S-2 Part I Date/Time Pre 1/28/2016 9:4	pared:
		Progran	n Name	Program Code	Unweighted IME FTE Count		
		1. (	0	2. 00	3. 00	4.00	
<ul> <li>61.10 Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instr column 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count.</li> <li>61.20 Of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded proginstructions) Enter in column 1,</li> </ul>	r of FTE residents uctions) Enter in r in column 2, the the IME FTE lumn 4, direct GME  fy each expanded he number of FTE ram. (see the program name,				0. 00		61. 10
enter in column 2, the program c 3, the IME FTE unweighted count 4, direct GME FTE unweighted cou	and enter in column					1.00	
ACA Provisions Affecting the Hea	Ith Pasources and Sar	rvi cas Admir	istration	(HDSA)		1.00	
62.00 Enter the number of FTE resident your hospital received HRSA PCRE 62.01 Enter the number of FTE resident	s that your hospital funding (see instruc	trained in tions)	this cost	reporting peri			62. 00 62. 01
during in this cost reporting pe Teaching Hospitals that Claim Re	riod of HRSA THC prog sidents in Nonprovide	ıram. (see i er Settings	nstructi o	ns)		N	63. 00
63.00 Has your facility trained reside "Y" for yes or "N" for no in col					Unweighted	Ratio (col. 1/	63.00
				FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
				Si te			
Section 5504 of the ACA Base Yea	r FTE Residents in No	onprovi der S	ettings	1.00 This base year	2.00 is your cost r	3.00 reporting	
period that begins on or after J 64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	uly 1, 2009 and befor yes, or your facilit ber of unweighted non tations occurring in number of unweighted ur hospital. Enter in	re June 30, ry trained raprimary ca all nonproval non-primar acolumn 3 t	2010. esidents re ider y care he ratio	0. 00	,		64. 00
jor (corumn r drvraca by (corumn	Program Name	Progran		Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2. (	10	Si te 3. 00	4.00	5.00	
65.00 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 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.00	0.00	0. 000000	65. 00

Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.

94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the

N

Ν

N

N

93 00

94.00

applicable column.

93 00

Health Financial Systems THOMAS H BOYD CRITICA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 141300	Period: From 09/01/ To 08/31/	2014	u of Form Workshee Part I Date/Tir 1/28/20	et S-2 me Pre	pared:
			V		XIX	(	- Cili
95.00 If line 94 is "Y", enter the reduction percentage in the appli 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes o			1. 00 N	0. 00	2. 00 N		95. 00 96. 00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the appli Rural Providers	cable colum	ın.		0. 00		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-in for outpatient services? (see instructions)		hod of paymen	t Y				105. 00 106. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost r training programs? Enter "Y" for yes or "N" for no in column 1 yes, the GME elimination is not made on Wkst. B, Pt. I, col. 2 reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CR	l. (see inst 25 and the p	ructions) If rogram is cos					107. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati ona	I Speech	h	Respi ra	atory	
	1.00	2.00	3.00		4.0		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	Y	Y		N		109. 00
					1. 0	0	-
110.00 Did this hospital participate in the Rural Community Hospital		on project (4º	10A Demo)for	-	N		110. 00
the current cost reporting period? Enter "Y" for yes or "N" fo	or no.			1. 00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "	'N" for no i	n column 1 l	f column 1	N		0	115. 00
is yes, enter the method used (A, B, or E only) in column 2. I 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers) Pub. 15-1, chapter 22, §2208.1.	f column 2 for long te	is "E", enter rm care (incl	in column udes			J	110.00
116.00 ls this facility classified as a referral center? Enter "Y" fo 117.00 ls this facility legally-required to carry malpractice insuran			"N" for	N Y			116. 00 117. 00
no.  118.00 Is the malpractice insurance a claims-made or occurrence police.							
	y? Enter 1	if the policy	is	2			118. 00
claim-made. Enter 2 if the policy is occurrence.	cy? Enter 1	if the policy  Premiums	is		Insura	ince	118. 00
	cy? Enter 1				Insura	ance	118. 00
claim-made. Enter 2 if the policy is occurrence.	cy? Enter 1	Premi ums	Losses 2.00	S	I nsura	0	
claim-made. Enter 2 if the policy is occurrence.	cy? Enter 1	Premi ums	2.00	0	3. 0	0 0	
claim-made. Enter 2 if the policy is occurrence.  118.01 List amounts of malpractice premiums and paid losses:  118.02 Are malpractice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul	enter other	Premi ums  1.00 128,8	Losses 2.00	0		0 0	118. 01
claim-made. Enter 2 if the policy is occurrence.  118.01 List amounts of malpractice premiums and paid losses:  118.02 Are malpractice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein.  119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in ce "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments	enter other e listing c Harmless pro column 1, "Y ifies for t	Premiums  1.00 128,8  than the ost centers  vision in ACA for yes or he Outpatient	2.00 15 1.00 N	0	3. 0	0 0	118. 01
claim-made. Enter 2 if the policy is occurrence.  118.01 List amounts of malpractice premiums and paid losses:  118.02 Are malpractice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	enter other e listing c darmless pro column 1, "Y ifies for t ?? (see inst	Premiums  1.00 128,8  than the ost centers  vision in ACA for yes or he Outpatient ructions)	2.00 15 1.00 N	0	3.00	0 0	118. 01 118. 02 119. 00 120. 00
claim-made. Enter 2 if the policy is occurrence.  118.01 List amounts of malpractice premiums and paid losses:  118.02 Are malpractice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for	enter other e listing c darmless pro column 1, "Y ifies for t ?? (see inst	than the ost centers  vision in ACA for yes or he Outpatient ructions) s charged to	2.00 15 1.00 N	0	3.00	0 0	118. 01 118. 02 119. 00 120. 00
claim-made. Enter 2 if the policy is occurrence.  118.01 List amounts of malpractice premiums and paid losses:  118.02 Are malpractice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.  Transplant Center Information	enter other e listing c darmless pro column 1, "Y ifies for t ?? (see inst cable device yes and "N"	Premi ums  1.00 128,8°  than the ost centers  vision in ACA "for yes or he Outpatient ructions) s charged to  for no. If	2.00 15 1.00 N	0	3.00	0 0	118. 01 118. 02 119. 00 120. 00
claim-made. Enter 2 if the policy is occurrence.  118.01 List amounts of malpractice premiums and paid losses:  118.02 Are malpractice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.	enter other e listing c Harmless pro column 1, "Y ifies for t s? (see inst cable device yes and "N"	Premiums  1.00 128,8:  than the ost centers  vision in ACA " for yes or he Outpatient ructions) as charged to  for no. If fication date	2.00 15 1.00 N	0	3.00	0 0	118. 01 118. 02 119. 00 120. 00 121. 00 125. 00 126. 00
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Health Financial Systems	THOMAS H BOYD CRI	TICAL ACC HOSPIT	AL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der	CCN: 141300		9/01/2014 8/31/2015	Worksheet S-2 Part I Date/Time Pre 1/28/2016 9:4	epared:
					1. 00	2.00	-
All Providers						2.00	
140.00 Are there any related organization chapter 10? Enter "Y" for yes or ' are claimed, enter in column 2 the	'N" for no in column 1. I	If yes, and home	office cost	S	N		140. 00
1.00	2	. 00			3. 00		
If this facility is part of a chain home office and enter the home office.				name and	d address	of the	
141. 00 Name:	Contractor's Name:	COITTI ACTOL TIUIIDE		tor's Nu	mber:		141. 00
142.00 Street:	PO Box:						142. 00
143. 00 Ci ty:	State:		Zi p Cod	9:			143. 00
						1.00	1
144.00 Are provider based physicians' cos	sts included in Workshee	t A?				Υ	144. 00
					1 00	2.00	4
145.00 If costs for renal services are cl	aimed on Wkst A line	74 are the costs	s for		1. 00 N	2. 00	145, 00
inpatient services only? Enter "Y' no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for no i	in column 1. If o	column 1 is				110.00
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	gy changed from the previ n column 1. (See CMS Pub.	,		f	N		146. 00
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				<u> </u>			
147.00Was there a change in the statisti	cal basis? Enter "V" for	r voc or "N" for	no			1. 00 N	147. 00
148.00 Was there a change in the order of		,				N N	148. 00
149.00 Was there a change to the simplifi						N	149. 00
		Part A	Part B	T	itle V	Title XIX	1
Does this facility contain a provi	der that qualifies for	1.00 an exemption from	2.00 n the applic	ation of	3.00 f the lowe	4.00 er of costs	
or charges? Enter "Y" for yes or '	'N" for no for each comp			(See 42			155 00
155. 00 Hospi tal 156. 00 Subprovi der – TPF		Y	Y N		N N	N N	155. 00 156. 00
157. 00 Subprovi der - IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER							158. 00
159.00 SNF 160.00 HOME HEALTH AGENCY		N N	N N		N N	N N	159. 00 160. 00
161. 00 CMHC		14	N N		N	N	161. 00
161. 10 CORF			N		N	N	161. 10
						1.00	+
Mul ti campus	mnua baanital that baa		ooo in diff	oront CD	2012	N	1/5 00
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus nospitai that has o	one or more campu	ises in diff	erent CB	SSAS?	IN IN	165. 00
	Name	County		ip Code	CBSA	FTE/Campus	-
166.00  f   line 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5. 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)							
W 111 1 C 11 T 1 1 1 1 1 1 1 1 1 1 1 1 1	r)					1. 00	
Health Information Technology (HI 167.00 s this provider a meaningful user 168.00 f this provider is a CAH (line 10	under §1886(n)? Enter O5 is "Y") and is a meani	"Y" for yes or " ingful user (line	'N" for no.		the	Y 859, 96	167. 00 6168. 00
reasonable cost incurred for the H 168.01 If this provider is a CAH and is r			qualify fo	r a hard	Ishi p		168. 01
exception under §413.70(a)(6)(ii)(169.00) If this provider is a meaningful transition factor. (see instruction	P Enter "Y" for yes or "i user (line 167 is "Y") an	N" for no. (see i	nstructi ons	)		0.00	169. 00
	,				gi nni ng 1. 00	Endi ng 2. 00	
170.00 Enter in columns 1 and 2 the EHR k	peginning date and ending	date for the re	eporting		1.00 '01/2014	09/30/2014	170. 00
period respectively (mm/dd/yyyy)	J	<i>y</i>					

Health Financial Systems	THOMAS H BOYD CRITICAL	ACC HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	ENTIFICATION DATA	Provider CCN: 141300	From 09/01/2014	Worksheet S-2 Part I Date/Time Pre 1/28/2016 9:4	pared:
			•		
				1.00	
171.00  f   line 167 is "Y", does this provider   Medicare cost plans reported on Wkst. (see instructions)				N	171. 00

		AS H BOYD CRITICAL				u of Form CMS-	
10SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE	Provi der	CCN: 141300	Peri od: From 09/01/2014 To 08/31/2015	Date/Time Pre	epared:
					Y/N	1/28/2016 9:4 Date	16 am
					1. 00	2. 00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	onses. Enter N for	all NO re	esponses. Ente	r all dates in t	he	
	Provider Organization and Operation						
. 00	Has the provider changed ownership immediatel reporting period? If yes, enter the date of t	y prior to the beginerate the change in column	nning of n 2. (see	instructions)		\//	1.00
				1. 00	2. 00	V/I 3. 00	
. 00	Has the provider terminated participation in yes, enter in column 2 the date of termination			N	2.00	3.00	2. 00
. 00	voluntary or "I" for involuntary. Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or f	, chain home office I to the provider on , or members of the	es, drug r its e board	N			3.00
	relationships? (see instructions)			Y/N	Type	Date	
				1.00	2. 00	3. 00	
. 00	Financial Data and Reports  Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Co	ompiled,	Y	A	03/01/2016	4. 00
. 00	column 3. (see instructions) If no, see instr Are the cost report total expenses and total those on the filed financial statements? If y	revenues different		N			5. 00
					Y/N	Legal Oper.	
	Approved Educational Activities				1.00	2. 00	
. 00	Column 1: Are costs claimed for nursing scho the legal operator of the program?	ool? Column 2: If	yes, is th	ne provider is	, N		6. 00
. 00	Are costs claimed for Allied Health Programs?				N		7. 00
00	Were nursing school and/or allied health prog cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents i	ns.		· ·	N		8. 00
. 00	program in the current cost report? If yes, s		uate medic	car education	N		9. 00
0. 00	Was an approved Intern and Resident GME progr cost reporting period? If yes, see instruction	ram initiated or rei ons.			N		10.00
1. 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		in an App	oroved	N		11. 00
						Y/N 1. 00	
	Bad Debts					1.00	
	Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad deb period? If yes, submit copy.				st reporting	Y N	12. 00 13. 00
4. 00	If line 12 is yes, were patient deductibles a Bed Complement	ind/or co-payments i	waived? If	fyes, see ins	tructions.	N	14. 00
5. 00	Did total beds available change from the prio	r cost reporting p	eriod? If	yes, see inst	ructions.	N	15. 00
		Dogani nti o			art A	Part B	
		Descriptio 0	n	Y/N 1.00	2.00	Y/N 3. 00	
	PS&R Data	Ţ,					
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)			Y	12/10/2015	Y	16. 00
7. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is			N		N	17. 00

	Report used in corullins 2 and 4 . (see			
	instructions)			
17. 00	Was the cost report prepared using the PS&R	N	N	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	N	N	18. 00
	made to PS&R Report data for additional			
	claims that have been billed but are not			
	included on the PS&R Report used to file			
	this cost report? If yes, see instructions.			
19. 00	If line 16 or 17 is yes, were adjustments	N	N	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	N	N	20.00
	made to PS&R Report data for Other? Describe			
	the other adjustments:			

alth Financial Systems	THOMAS H BOYD CRITICAL ACC HOSPITAL	In Lieu

of Form CMS-2552-10 Hea HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 141300 Peri od Worksheet S-2 From 09/01/2014 Part II 08/31/2015 Date/Time Prepared: 1/28/2016 9:46 am Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting Υ 28.00 period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Υ 33.00 33.00 no, see instructions. Provi der-Based Physi ci ans Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based Υ 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 N 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? N 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position JIM JOHNSON 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel v. THOMAS H. BOYD MEMORIAL 42.00 42.00 Enter the employer/company name of the cost report HOSPI TAI preparer. 43.00 Enter the telephone number and email address of the cost 217. 942. 6946 JJOHNSON@BOYDHCS. ORG 43.00 report preparer in columns 1 and 2, respectively.

report preparer in columns 1 and 2, respectively.

THOMAS H BOYD CRITICAL ACC HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 141300 Peri od: Worksheet S-2 From 09/01/2014 To 08/31/2015 Part II Date/Time Prepared: 1/28/2016 9:46 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 12/10/2015 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 instructions) 17.00 Was the cost report prepared using the PS&R 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 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position CF0 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 43.00 
 Heal th Financial
 Systems
 THOMAS H BOY

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 141300

| Peri od: | Worksheet S-3 | From 09/01/2014 | Part | To 08/31/2015 | Date/Time Prepared: | 1/28/2016 9: 46 am

							1/28/2016 9: 4	<u>6 am</u>
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2.00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 125	9, 395. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4. 00	HMO IRF Subprovider							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			25	9, 125	9, 395. 00	0	7. 00
7.00	beds) (see instructions)			20	7, 120	7, 070. 00	o o	7.00
8.00	INTENSIVE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14.00	Total (see instructions)			25	9, 125	9, 395. 00	0	14.00
15. 00	CAH visits						0	15.00
16. 00	SUBPROVI DER - I PF	40. 00		0	0		0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00		0	0		0	17. 00
18. 00	SUBPROVI DER	42. 00		0	0		0	18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY	45. 00		0	0		0	20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	445.00						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	115. 00						23. 00
24. 00	HOSPI CE	00.00						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00 25. 10	CMHC - CMHC CMHC - CORF	99. 10					0	25. 00 25. 10
26. 00	RHC (CONSOLIDATED)	88. 00	l .				0	26. 00
26. 00	FEDERALLY QUALIFIED HEALTH CENTER	89. 00 89. 00	l .				0	26. 00
27. 00	Total (sum of lines 14-26)	69.00		25			U	27. 00
28. 00	Observation Bed Days			25			0	28. 00
29. 00	Ambulance Trips							29. 00
30. 00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days (see l'instruction)							31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32. 00
32. 00	Total ancillary labor & delivery room			٩	O			32. 00
02.01	outpatient days (see instructions)							52.01
33. 00	LTCH non-covered days							33. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 141300

Peri od: Worksheet S-3 From 09/01/2014 Part I To 08/31/2015 Date/Time Prepared:

1/28/2016 9:46 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 7.00 6.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 294 43 435 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 34 3.00 HMO IPF Subprovider 0 0 3.00 HMO IRF Subprovider 4.00 4.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 5.00 571 571 Hospital Adults & Peds. Swing Bed NF 6.00 C 32 6.00 7.00 Total Adults and Peds. (exclude observation 865 43 1,038 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 865 43 1,038 0.00 103.25 14.00 CAH visits 15.00 0 0 15.00 0 SUBPROVIDER - IPF 0.00 0.00 16.00 0 0 16.00 SUBPROVIDER - IRF 0 0.00 17.00 0 0.00 17.00 18.00 SUBPROVI DER 0 0 0 0.00 0.00 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY Ω 0 0 00 0.00 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 0.00 0.00 23.00 HOSPI CE 24.00 24.00 24. 10 HOSPICE (non-distinct part) 0 0 0 24.10 25. 00 CMHC - CMHC 25.00 25. 10 CMHC - CORF 0.00 0.00 25. 10 RHC (CONSOLIDATED) 18. 90 26.00 14, 943 0.00 4, 124 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER C 0.00 0.00 26. 25 Total (sum of lines 14-26) 0.00 122.15 27.00 Observation Bed Days 28.00 0 180 28.00 29 00 Ambul ance Trips 0 29 00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 0 0 32.00 Ω 32.00 Total ancillary labor & delivery room 0 32.01 outpatient days (see instructions) LTCH non-covered days 33.00

| Peri od: | Worksheet S-3 | From 09/01/2014 | Part | To 08/31/2015 | Date/Time Prepared: Health Financial Systems THOMAS H BOYHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 141300

				10	08/31/2015	1/28/2016 9:4	
		Full Time	<u> </u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	10.00	14.00	Pati ents	
1 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12. 00	13.00	14. 00	15. 00 167	1, 00
1. 00	8 exclude Swing Bed, Observation Bed and		U	110	20	107	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00 14. 00	NURSERY	0. 00	0	110	20	167	13.00
15. 00	Total (see instructions) CAH visits	0.00	U	110	20	107	14. 00 15. 00
16. 00	SUBPROVI DER - I PF	0.00	0	o	0	0	16.00
17. 00	SUBPROVI DER - I RF	0.00	0		0	0	
18. 00	SUBPROVI DER	0.00	0		0	0	18. 00
19. 00	SKILLED NURSING FACILITY					_	19. 00
20.00	NURSING FACILITY	0.00					20. 00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0. 00					23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0.00					25. 10
26. 00	RHC (CONSOLI DATED)	0.00					26. 00
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	0. 00 0. 00					26. 25 27. 00
28. 00	Total (sum of lines 14-26) Observation Bed Days	0.00					28.00
29. 00	Ambul ance Trips						29.00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00

near tr	n Financial Systems THOM	AS H BOYD CRITICAL	ACC HOSPI	TAL	In Lie	eu of Form CM	IS-2	552-10
	TAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFI STICAL DATA	ED HEALTH CENTER		CCN: 141300 t CCN: 143403	Peri od: From 09/01/2014 To 08/31/2015		rep	
					Rural Health Clinic (RHC) I	Cos		, am
					1	00		
	Clinic Address and Identification					. 00		
1.00	Street				800 SCHOOL STF		$\Box$	1. 00
				00	State 2.00	ZIP Code 3.00	_	
2.00	City, State, ZIP Code, County	CARI	ROLLTON 1.	00		62016	_	2.00
		-						
3.00	FQHCs ONLY: Designation - Enter "R" for rural	or "U" for urban				1. 00	0	3. 00
0.00	Tenos oner: bosignation Enter K for rarai	or o ror urban			Grant Award	Date		0.00
					1. 00	2. 00		
4 00	Source of Federal Funds	A a + \						4 00
4. 00 5. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac					1		4. 00 5. 00
6. 00	Health Services for the Homeless (Section 340							6. 00
7. 00	Appal achi an Regi onal Commissi on	(2),						7. 00
8.00	Look-Alikes				(	1		8. 00
9. 00	OTHER (SPECIFY)							9. 00
					1. 00	2.00	+	
10. 00	Does this facility operate as other than an R no in column 1. If yes, indicate number of ot subscripts of line 11 the type of other operations.	her operations in	column 2. (	(Enter in		2.00	0	10. 00
	Subscripts of Time II the type of other opere	Sunday	peratring ne	· · · · · · · · · · · · · · · · · · ·	londay	Tuesday		
		from	to	from	to	from		
	[: :t.,	1. 00	2. 00	3. 00	4. 00	5. 00		
11. 00	Facility hours of operations (1)	07: 00 19: (	00	07: 00	19: 00	07: 00		11. 00
				1				
10.00				10	1. 00	2. 00		10.00
12. 00 13. 00	1 3 11	lin CMS Pub. 100- umn 1. If yes, ent	04, chapter er in colum	9, section nn 2 the	Y		4	12. 00 13. 00
					der name	CCN number	· ]	
14. 00	Provider name, CCN number			_	1.00 Y RURAL HEALTHC	2. 00	-	14. 00
14. 00	Provider Halle, CON Hulliber			CLINIC	D RURAL HEALTH	143475		14. 00
14. 02				CLINIC BOYD-FILLAGE	R CLINIC -	143474		14. 02
14. 03				GREENFIELD RURAL HEALTH ROODHOUSE	CENTER OF	143476		14. 03
		Y/N	V	XVIII	XIX	Total Visit	S	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V. XVIII, and	1.00	2.00	3.00	4. 00	5. 00		15. 00

Health Financial Systems THOM	AS H BOYD CRIT	ICAL ACC HOSPI	ΓAL	In Lie	eu of Form CMS-	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	TED HEALTH CEN	TER Provi der	CCN: 141300	Peri od:	Worksheet S-8	3
STATISTICAL DATA		Component	t CCN: 143403	From 09/01/2014 To 08/31/2015		
				Rural Health	Cost	
				Clinic (RHC) I		
		Cou	ınty			
		4.	00			
2.00 City, State, ZIP Code, County	_		-			2. 00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 Clinic	19: 00	07: 00	19: 00	07: 00	19: 00	11. 00
	Fri	day Sat		turday		
	from	to	from	to		
	11. 00	12.00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 Cl i ni c	07: 00	19: 00	07: 00	19: 00		11. 00
·	•	•	•	•		•

	Financial Systems THOMAS H BOYD CRITICAL ACC			eu of Form CMS-2		
HOSPI I	FAL UNCOMPENSATED AND INDIGENT CARE DATA	ovider CCN: 141300	Period: From 09/01/2014	Worksheet S-1	0	
			To 08/31/2015	Date/Time Pre	nared·	
			10 00/01/2010	1/28/2016 9: 4		
	· · · · · · · · · · · · · · · · · · ·		<u> </u>			
				1. 00		
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	by line 202 col	umn 8)	0. 621347	1.00	
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			1, 380, 244	2. 00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3. 00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental pay	ments from Medic	ai d?		4. 00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Med			0	5. 00	
6.00	Medi cai d charges			3, 394, 599	6. 00	
7.00	Medicaid cost (line 1 times line 6)			2, 109, 224	7. 00	
8.00	Difference between net revenue and costs for Medicaid program (line	e 7 minus sum of	lines 2 and 5; if	728, 980	8. 00	
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instructions	for each line)				
9.00	Net revenue from stand-alone SCHIP			0	9. 00	
10.00	Stand-allone SCHIP charges			0	10.00	
11. 00	Stand-alone SCHIP cost (line 1 times line 10)			0	11. 00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (lir	ne 11 minus line	9; if < zero then	0	12. 00	
	enter zero)					
	Other state or local government indigent care program (see instruct	ions for each li	ne)			
13.00	Net revenue from state or local indigent care program (Not included	d on lines 2, 5 o	r 9)	0	13. 00	
14.00	4.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or					
	10)					
15.00	State or local indigent care program cost (line 1 times line 14)			0	15. 00	
16.00	Difference between net revenue and costs for state or local indiger	nt care program (	line 15 minus line	0	16. 00	
	13; if < zero then enter zero)					
	Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to fundir				17. 00	
18. 00	Government grants, appropriations or transfers for support of hospi			0		
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local ir	ndigent care prog	rams (sum of lines	728, 980	19. 00	
	8, 12 and 16)					
		Uni nsure		Total (col. 1		
		pati ent		+ col . 2)		
00.00	T	1.00	2. 00	3. 00	00.00	
20. 00	Total initial obligation of patients approved for charity care (at		, 592 108, 846	144, 438	20.00	
21. 00	charges excluding non-reimbursable cost centers) for the entire fac		115 47 401	89. 746	21 00	
21.00	Cost of initial obligation of patients approved for charity care (I times line 20)	The I	, 115 67, 631	89, 740	21. 00	
22.00			4/1 2.220	7 701	22.00	
22. 00	Partial payment by patients approved for charity care	•	, 461 3, 330 , 654 64, 301		22. 00	
23.00	Cost of charity care (line 21 minus line 22)	17	, 654 64, 301	81, 955	23.00	
				1. 00		
24. 00	Does the amount in line 20 column 2 include charges for patient day	is havend a Langt	h of stay limit	1.00 N	24. 00	
24.00	imposed on patients covered by Medicaid or other indigent care proc		i oi Stay IIIIII l	I IN	24.00	
25 00	If line 24 is "yes," charges for patient days beyond an indigent of		nath of stav limit	0	25. 00	
	Total bad debt expense for the entire hospital complex (see instruc		ngth of Stay IIIII t	591, 626		
	Medicare bad debts for the entire hospital complex (see instruction			103, 549	1	
	Non-Medicare and non-reimbursable Medicare bad debt expense (Line 2			488 077		

28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)

30.00 Cost of uncompensated care (line 23 column 3 plus line 29)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)

303, 265 29. 00 385, 220 30. 00 1, 114, 200 31. 00

488, 077

28.00

Heal th	Financial Systems THOM	MAS H BOYD CRITICAL	ACC HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der	CCN: 141300	Peri od:	Worksheet A	
					From 09/01/2014 To 08/31/2015	Date/Time Pre	narod:
					10 06/31/2013	1/28/2016 9: 4	
	Cost Center Description	Sal ari es	Other	Total (col.	Reclassi fi cati	Reclassi fi ed	
	·			+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT		453, 168			49, 831	1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT NON HOSP.		0	)	0 14, 443	14, 443	1. 01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0		0 469, 428	469, 428	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS		024 500	024 50	0 70 400	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0 40 005	834, 589			907, 071	4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	840, 235 58, 008	943, 562	l .			5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE		139, 801	1		205, 896 38, 841	7. 00 8. 00
9. 00	00900 HOUSEKEEPING	29, 429 87, 108	9, 412 34, 802	1		130, 000	1
10. 00	01000 DI ETARY	151, 015	50, 375	1		201, 390	1
11. 00	01100 CAFETERI A	131,013	30, 373			201, 370	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	120, 755	10, 610	Ί	9	131, 365	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	26, 626	61, 106	1		87, 732	
15. 00	01500 PHARMACY	0	214, 967	1		214, 967	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	126, 428	12, 169		-	138, 597	
23. 00	02300 PARAMED ED PRGM	0	.2, .0,		o o	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS		-		-1		
30.00	03000 ADULTS & PEDI ATRI CS	989, 181	160, 066	1, 149, 24	7 -15, 650	1, 133, 597	30.00
40.00	04000 SUBPROVI DER - I PF	0	0		o o	0	40. 00
41.00	04100 SUBPROVI DER - I RF	0	0		o o	0	41.00
42.00	04200 SUBPROVI DER	0	0		0 0	0	42.00
45.00	04500 NURSING FACILITY	0	0		0 0	0	45. 00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	359, 461	264, 802	624, 26	3 -69, 403	554, 860	
57. 00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59. 00
60.00	06000 LABORATORY	378, 840	314, 815	693, 65	5 1, 657	695, 312	
60. 01	06001 BLOOD LABORATORY	0	0	2	0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	( 20(	, ,,	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	6, 306	6, 30	6 517	6, 823	1
64. 00 66. 00	06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY	257, 026	64, 531	321, 55	7	0 321, 557	64. 00 66. 00
69. 00	06900 ELECTROCARDI OLOGY	237, 020	27, 497	1		45, 945	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		27, 497	27,49	0 10, 440	45, 445	71.00
71. 30	07100 MEDICAL SUPPLIES CHARGED TO PATTENTS		0		0	0	71. 30
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT		0		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
76. 00	03030 ANGI OCARDI OGRAPHY	o o	0	ó	o o	0	76.00
	OUTPATIENT SERVICE COST CENTERS		-		-1		
88. 00	08800 RURAL HEALTH CLINIC	1, 392, 953	177, 187	1, 570, 14	0 -249, 420	1, 320, 720	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		o o	0	1
90.00	09000 CLI NI C	5, 967	296	6, 26	3 0	6, 263	90.00
91.00	09100 EMERGENCY	1, 165, 057	346, 872	1, 511, 92	9 35, 694	1, 547, 623	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 00	04050 TELEMEDI CI NE	0	0		0 0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	359, 893	105, 527	465, 42	0 0	465, 420	
98. 00	09851 OTHER REIMBURSABLE COST CENTERS	0	0	1	0	0	
99. 10	09910 CORF	0	0	)	0 0	0	99. 10
	SPECIAL PURPOSE COST CENTERS				_1		
	10900 PANCREAS ACQUISITION	0	0	)	0		109.00
	11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
	11100 ISLET ACQUISITION  11300 INTEREST EXPENSE	l o	0		0 (0 444		111.00
	11300  INTEREST EXPENSE   11400  UTI LI ZATI ON REVI EW-SNF		0		0 -60, 444	-60, 444	114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)		0		0		115.00
	06951 OTHER SPECIAL PURPOSE COST CENTERS		0		0		117. 00
118.00		6, 347, 982	4, 232, 460	10, 580, 44	2 -2, 489	10, 577, 953	
. 10. 00	NONREI MBURSABLE COST CENTERS	5, 577, 702	1, 202, 400	, 10, 300, 44	-, -2, 407	10, 011, 700	1 . 3. 30
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0		0 0	0	190. 00
	19100 RESEARCH	l ol	n	o	ol ől		191. 00
	19300 NONPALD WORKERS	O	0		ol ol		193. 00
	07951 OTHER NONREIMBURSABLE COST CENTERS	48, 586	1, 403	49, 98	9 2, 489		194. 00
200.00	TOTAL (SUM OF LINES 118-199)	6, 396, 568	4, 233, 863	10, 630, 43	1 0	10, 630, 431	200. 00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 141300 | Peri od: | From 09/01/2014

od: Worksheet A 09/01/2014 08/31/2015 Date/Time Prepared:

1/28/2016 9:46 am Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6.00 7.00 GENERAL SERVICE COST CENTERS -5, 472 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 44, 359 1.00 00101 CAP REL COSTS-BLDG & FIXT NON HOSP. 1.01 14, 443 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 -310,067 159.361 2.00 00300 OTHER CAPITAL RELATED COSTS 3 00 3 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 907, 071 4.00 -249, 353 00500 ADMINISTRATIVE & GENERAL 1, 701, 363 5.00 5.00 7.00 00700 OPERATION OF PLANT 205, 896 7.00 0 00800 LAUNDRY & LINEN SERVICE 8.00 0 38.841 8 00 9.00 00900 HOUSEKEEPI NG 130,000 9.00 10.00 01000 DI ETARY -32,942168, 448 10 00 01100 CAFETERIA 11 00 11 00 0 01300 NURSING ADMINISTRATION 13.00 0 131, 365 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 87, 732 14.00 01500 PHARMACY 15.00 214.967 15.00 0 01600 MEDICAL RECORDS & LIBRARY -5.867 16.00 132, 730 16.00 23.00 02300 PARAMED ED PRGM 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 0 1, 133, 597 04000 SUBPROVIDER - IPF 0 40 00 C 40 00 04100 SUBPROVIDER - IRF 0 41.00 0 41.00 04200 SUBPROVI DER 0 42.00 Ω 42.00 04500 NURSING FACILITY 45.00 0 0 45.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 554.860 54.00 0 57.00 05700 CT SCAN 57.00 C 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 60.00 -350 694, 962 60.00 06001 BLOOD LABORATORY 60.01 0 C 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 6,823 63.00 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 66 00 06600 PHYSI CAL THERAPY -51 022 270, 535 66 00 06900 ELECTROCARDI OLOGY 69.00 -27, 497 18, 448 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 0 C 71.30 07101 IMPL. DEV. CHARGED TO PATIENT 0 71.30 0 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 Ω 73.00 03030 ANGI OCARDI OGRAPHY 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 1, 294 1, 322, 014 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 90.00 6, 263 09100 EMERGENCY -158, 577 91 00 1, 389, 046 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 93.00 04050 TELEMEDI CI NE 93.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 110.951 95 00 -354.46998.00 09851 OTHER REIMBURSABLE COST CENTERS 98.00 09910 CORF 99. 10 0 0 99.10 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 109 00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 0 111.00 11100 I SLET ACQUISITION 0 111.00 113.00 11300 INTEREST EXPENSE 60, 444 0 113.00 114.00 11400 UTILIZATION REVIEW-SNF 0 0 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 0 117. 00 06951 OTHER SPECIAL PURPOSE COST CENTERS 117. 00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 118.00 -1, 133, 878 9, 444, 075 118.00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 191. 00 19100 RESEARCH 0 191.00 0 193. 00 19300 NONPALD WORKERS 0 Λ 193. 00 194. 00 07951 OTHER NONREIMBURSABLE COST CENTERS 52, 478 194. 00 TOTAL (SUM OF LINES 118-199) 200.00 -1, 133, 878 9, 496, 553 200.00

Health Financial Systems RECLASSIFICATIONS THOMAS H BOYD CRITICAL ACC HOSPITAL Provider CCN: 141300 In Lieu of Form CMS-2552-10 

					Date/lime Prepai 1/28/2016 9:46 a
		Increases			1.5.5
	Cost Center	Li ne #	Salary	Other 5.00	
Λ [	2.00 RECLASS DEPRECIATION EXPE	3.00	4. 00	5. 00	
	REL COSTS-BLDG & FLXT	1. 01	ol	5, 730	
NON H		1.01	Ĭ	0, 700	
NEW (	CAP REL COSTS-MVBLE	2.00	0	396, 243	
EQUI F	1				
	_ HEALTH CLINIC		0	<u>2, 000</u>	
TOTAL			0	403, 973	
	RECLASS INTEREST EXPENSE CAP REL COSTS-MVBLE	2.00	ol	6, 580	
EQUI F		2.00	٥	0, 380	
	NISTRATIVE & GENERAL	5. 00	o	53, 864	
TOTAL				60, 444	
C - F	RECLASS SALARIES TO EKG C	OST CENTER			
	TROCARDI OLOGY	69. 00	17, 137	1, 311	
L .		0.00	0	0	
TOTAL			17, 137	1, 311	
	RECLASS RHC INSURANCE ACC		al	70. 400	
	OYEE BENEFITS DEPARTMENT	4.00	0	72, 482	
FLXT	CAP REL COSTS-BLDG &	1. 00	0	636	
TOTAL	$\overline{\varsigma}$ $$ $$ $-$	+		73, 118	
	NURSING ADMIN SALARY AND	BENEFLTS	٥	73, 110	
	TOTAL TIES A STATE OF TEXT AND	0.00	0	0	
TOTAL				- — <u> </u>	
F - F	RECLASS RHC ADMIN COSTS	•			
ADMI N	NISTRATIVE & GENERAL	5. 00	0	9, 920	
0PER/	ATION OF PLANT	7.00	0	8, 087	
		0.00	0	0	
		0.00	•	0	
TOTAL		IOUGEWEED NO	0	18, 007	
	RHC BUSINESS OFFICE AND H		157 004	7.7/5	
	NISTRATIVE & GENERAL EKEEPING	5. 00 9. 00	156, 824 7, 630	7, 765 460	
110031	INLLFING	0.00	7, 030	0	
		0.00	0	0	
TOTAL			164, 454	8, 225	
	RHC LAB TIME				
LABOR	RATORY	60.00	2, 043	131	
	STORING, PROCESSING &	63. 00	482	35	
TRANS	S.		_		
		0.00	0	0	
TOTAL				0	
	_S RECLASSIFY ER ADMIN TIME		2, 525	100	
	VISTRATIVE & GENERAL	5. 00	17, 686	1, 334	
	NISTRATIVE & GENERAL	5. 00	0	5, 507	
TOTAL			17, 686	6, 841	
	RECLASS LEASES TO CAPITAL		,		
	CAP REL COSTS-MVBLE	2.00	0	66, 605	
EQUI F					
		0.00	0	0	
TOTAL			0	66, 605	
	RHC SALARY TO ER	01.00	77 477		
EMER(		91.00	7 <u>7, 4</u> 77 77, 477	<u>0</u>	
	_S ER PHYS. SAL TO RHC CARRO	I TON	11,411	U	
	HEALTH CLINIC	88. 00	9, 205	2, 301	
TOTAL			$\frac{7,205}{9,205}$	$-\frac{2,301}{2,301}$	
	PROPERTY TAXES		., ====	, , , , ,	
	REL COSTS-BLDG & FLXT	1. 01	0	8, 713	
NON H					
	_ HEALTH CLINIC	88.00	0	1, 661	
	R NONREI MBURSABLE COST	194. 00	0	2, 489	
CENTE		+		12.0/2	
TOTAL	_S CONTINUING EDUCATION COST	'S IN ED	0	12, 863	
	HEALTH CLINIC	88.00	0	5, 750	
TOTAL			0	- <u>5, 750</u> 5, 750	
	AMBULANCE I NSURANCE		9	5, 700	
,		0.00	0	0	
				- — <u> </u>	
TOTAL	_S	1	OI OI	U	

Health Financial Systems RECLASSIFICATIONS THOMAS H BOYD CRITICAL ACC HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 141300

Peri od: From 09/01/2014 To 08/31/2015 Date/Ti me Prepared:

						16 9: 46 am
		Decreases		·		
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10. 00	
	A - RECLASS DEPRECIATION EXPE					
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	403, 973	9	1. 00
0.00	FIXT	0.00				0.00
2.00		0.00	0	C	9	2. 00
3.00	TOTAL C — — — — —	0.00	— — <del>0</del>		<u> </u>	3. 00
	TOTALS  B - RECLASS INTEREST EXPENSE		U	403, 973		
1.00	INTEREST EXPENSE	113.00	0	60, 444	11	1. 00
2.00	INTEREST EXPENSE	0.00	0	00, 444		2.00
2.00	TOTALS — — — —			60, 444		2.00
	C - RECLASS SALARIES TO EKG O	OST CENTER	<u> </u>	00, 444		
1.00	ADULTS & PEDIATRICS	30.00	4, 913	376	0	1. 00
2. 00	RADI OLOGY-DI AGNOSTI C	54.00	12, 224	935		2. 00
2.00	TOTALS		17, 137	1, 311		2.00
	D - RECLASS RHC INSURANCE ACC	OUNTS	,	.,		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	73, 118	0	1. 00
2.00		0.00	o		12	2. 00
	TOTALS			73, 118		
	E - NURSING ADMIN SALARY AND	BENEFI TS				
1.00		0.00	0			1. 00
	TOTALS		0			
	F - RECLASS RHC ADMIN COSTS					
1.00	RURAL HEALTH CLINIC	88. 00	0	2, 746		1. 00
2.00	RURAL HEALTH CLINIC	88. 00	0	9, 443		2. 00
3.00	RURAL HEALTH CLINIC	88. 00	0	3, 805		3. 00
4.00	RURAL HEALTH CLINIC		•	<u>2, 0</u> 13		4. 00
	TOTALS		0	18, 007		
	G - RHC BUSINESS OFFICE AND H					
1.00	RURAL HEALTH CLINIC	88. 00	11, 331	326		1. 00
2.00	RURAL HEALTH CLINIC	88. 00	73, 347	2, 005		2. 00
3.00	RURAL HEALTH CLINIC	88. 00	57, 406	3, 961		3. 00
4. 00	RURAL HEALTH CLINIC	8800	22, 370			4. 00
	TOTALS H - RHC LAB TIME		164, 454	8, 225		
1. 00	RURAL HEALTH CLINIC	88. 00	314	9	0	1. 00
2.00	RURAL HEALTH CLINIC	88. 00	1, 565	108		2.00
3.00	RURAL HEALTH CLINIC	88. 00	1, 363	14	1	3. 00
4.00	LABORATORY	60.00	482	35		4. 00
4.00	TOTALS		2, 525	35		4.00
	I - RECLASSIFY ER ADMIN TIME		2, 323	100	'	
1.00	EMERGENCY	91. 00	17, 686	1, 334	0	1. 00
2. 00	EMERGENCY	91.00	17,000	5, 507		2. 00
2.00	TOTALS		17, 686			2.00
	J - RECLASS LEASES TO CAPITAL		,	-, -, -		
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	56, 244	10	1. 00
2.00	ADULTS & PEDIATRICS	30.00	o	10, 361		2. 00
	TOTALS			66, 605	5	1
	K - RHC SALARY TO ER	·			•	
1.00	RURAL HEALTH CLINIC	88. 00	77, 477			1. 00
	TOTALS		77, 477			
	L - ER PHYS. SAL TO RHC CARRO					
1.00	EMERGENCY	91.00	<u>9, 2</u> 05	<u>2, 3</u> 01		1. 00
	TOTALS		9, 205	2, 301		
	M - PROPERTY TAXES					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	12, 863		1. 00
2.00		0.00	0	C	0	2. 00
3.00		0.00		ç	<u> </u>	3. 00
	TOTALS	C IN 50	0	12, 863	<u> </u>	
1 00	O - CONTINUING EDUCATION COST		cl	E 750		
1. 00	EMERGENCY	91.00				1. 00
	TOTALS		0	5, 750	<u> </u>	
1 00	P - AMBULANCE I NSURANCE	0.00	ما			1 00
1. 00	TOTALS — — — —				9 9	1.00
500 00	Grand Total: Decreases		288, 484	659, 604		500. 00
500. UL	Joi and Total. Decleases	I	200, 404	009, 004	1	J 500. 00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 141300 Peri od: Worksheet A-7 From 09/01/2014 Part I Date/Time Prepared: 08/31/2015 1/28/2016 9:46 am Acqui si ti ons Begi nni ng Purchases Di sposal s and Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 70, 513 0 1.00 0 2.00 Land Improvements 36, 143 0 2.00 1, 383, 251 0 3.00 5, 985 5, 985 3.00 Buildings and Fixtures 0 1, 155, 739 0 4.00 Building Improvements 0 4.00 5.00 Fixed Equipment 84, 027 0 5.00 0 6.00 Movable Equipment 3, 065, 923 9,000 9.000 9,000 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 5, 795, 596 14, 985 14, 985 9,000 8.00 9.00 Reconciling Items 0 9.00 5, 795<u>,</u> 596 14, 985 Total (line 8 minus line 9) 9,000 10.00 0 14.985 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 70, 513 1.00 2.00 Land Improvements 36, 143 2.00 36, 143 1, 220, 714 1. 389. 236 3.00 Buildings and Fixtures 3.00 4.00 Building Improvements 1, 155, 739 1, 059, 977 4.00 5.00 Fi xed Equipment 84, 027 81, 707 5.00 Movable Equipment 6.00 3, 065, 923 1, 644, 564 6.00 7.00 HIT designated Assets 7.00 Ω

5, 801, 581

5, 801, 581

4, 043, 105

4, 043, 105

CAP REL COSTS-BLDG & FIXT NON HOSP.

NEW CAP REL COSTS-MVBLE EQUIP

Total (sum of lines 1-2)

1.01

2.00

3.00

1.01

2.00

3.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 141300 Peri od: Worksheet A-7 From 09/01/2014 Part II Date/Time Prepared: То 08/31/2015 1/28/2016 9:46 am SUMMARY OF CAPITAL Insurance (see Taxes (see Depreciation Interest Cost Center Description Lease instructions) instructions) 10.00 11.00 12.00 9.00 13.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 NEW CAP REL COSTS-BLDG & FIXT 431, 892 0 21, 276 0 1.00 0 1.01 CAP REL COSTS-BLDG & FIXT NON HOSP. 0 0 0 1.01 0 2.00 NEW CAP REL COSTS-MVBLE EQUIP 2.00 0 Ω 0 0 3.00 Total (sum of lines 1-2) 431, 892 0 21, 276 0 3.00 SUMMARY OF CAPITAL Other Total (1) (sum Capital-Relate of cols. 9 Cost Center Description of cols. 9 d Costs (see through 14) instructions) 14. 00 15. 00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 453, 168 1.00

0

0

0

453, 168

Health Financial Systems	THOMAS H BOYD CRITICAL ACC HOSPITAL	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 141300	Peri od: Worksheet A-7

COMPUTATION OF RATIOS   ALLOCATION OF OTHER CAPITAL	1. 00 1. 01 2. 00 3. 00
Leases   for Ratio   instructions	1. 01 2. 00
PART       -   RECONCILIATION OF CAPITAL COSTS CENTERS	1. 01 2. 00
PART       - RECONCILIATION OF CAPITAL COSTS CENTERS	1. 01 2. 00
1.00 NEW CAP REL COSTS-BLDG & FIXT 2,510,585 0 2,510,585 0.476220 0 1.01 CAP REL COSTS-BLDG & FIXT NON HOSP. 0 0 0.000000 0 2.00 NEW CAP REL COSTS-MVBLE EQUIP 2,761,318 0.523780 0 3.00 Total (sum of lines 1-2) 5,271,903 0 5,271,903 1.00000 0  ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL  Cost Center Description Taxes 0ther Capital -Relate d Costs 5 through 7)	1. 01 2. 00
1.01 CAP REL COSTS-BLDG & FIXT NON HOSP. 2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)  Cost Center Description  Cost Center De	1. 01 2. 00
2. 00 NEW CAP REL COSTS-MVBLE EQUIP 2, 761, 318 0 2, 761, 318 0 5, 271, 903 0 5, 271, 903 1. 000000 0  ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL  Cost Center Description Taxes Other Capital -Relate d Costs through 7)	2. 00
3.00   Total (sum of lines 1-2)   5,271,903   0   5,271,903   1.000000   0	3. 00
Cost Center Description  Taxes  Other Capital -Relate cols. 5 through 7)  Cost Center Description  Lease	
Capital-Relate cols. 5 d Costs through 7)	
d Costs through 7)	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS	
1.00 NEW CAP REL COSTS-BLDG & FIXT O O O 22,447 O	1. 00
1.01 CAP REL COSTS-BLDG & FIXT NON HOSP. 0 0 5,730 0	1. 01
2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 396, 243 66, 605	2. 00
3.00 Total (sum of lines 1-2) 0 0 424,420 66,605	3.00
SUMMARY OF CAPITAL	
Cost Center Description Interest Insurance (see Taxes (see Other Total (2) (sum	
instructions   instructions   Capital -Relate   of cols. 9	
d Costs (see through 14)	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS	
1.00 NEW CAP REL COSTS-BLDG & FIXT 0 21, 912 0 0 44, 359	1. 00
1. 01 CAP REL COSTS-BLDG & FIXT NON HOSP. 0 0 8, 713 0 14, 443	1. 01
2.00 NEW CAP REL COSTS-MVBLE EQUIP -303, 487 0 0 0 159, 361	2. 00
3.00   Total (sum of lines 1-2)   -303, 487   21, 912   8, 713   0   218, 163	3.00

Health Financial Systems THOMAS H BOYD CRITICAL ACC HOSPITAL In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 141300 Peri od: Worksheet A-8 From 09/01/2014 08/31/2015 Date/Time Prepared: 1/28/2016 9:46 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basi s/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1. 00 1.00 REL COSTS-BLDG & FLXT (chapter IFI XT 1.01 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1.01 1.01 COSTS-BLDG & FIXT NON HOSP. NON HOSP. (chapter 2) -1, 427 NEW CAP REL COSTS-MVBLE 2 00 Investment income - NEW CAP 2 00 В 2 00 11 REL COSTS-MVBLE EQUIP (chapter FOUL P 3.00 Investment income - other -11, 682 ADMINI STRATI VE & GENERAL 5.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 di scounts (chapter 8) 5.00 Refunds and rebates of 5.00 0.00 expenses (chapter 8) 6.00 Rental of provider space by 0.00 6.00 suppliers (chapter 8) Telephone services (pay 0.00 7.00 7.00 stations excluded) (chapter 21) Tel evi si on and radi o servi ce -1, 679 ADMI NI STRATI VE & GENERAL 8.00 Α 5.00 8.00 (chapter 21) 9.00 Parking lot (chapter 21) 9.00 0.00 Provider-based physician A-8-2 -186, 074 10.00 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0 0 00 11.00 (chapter 23) 12.00 Related organization A-8-1 0 12.00 transactions (chapter 10) Laundry and linen service 13.00 0.00 13.00 -32, 942 DI ETARY 14.00 Cafeteria-employees and guests В 14.00 10.00 0 15.00 Rental of quarters to employee 0.00 15.00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than pati ents 17.00 17.00 Sale of drugs to other than 0.00 0 pati ents 18.00 Sale of medical records and -5, 867 MEDI CAL RECORDS & LI BRARY 18.00 16.00 abstracts Nursing school (tuition, fees, 19.00 19.00 0 0.00 books, etc.) 20.00 Vending machines 0 0.00 20 00 Income from imposition of 0 21.00 21.00 0.00 interest, finance or penalty charges (chapter 21) 22 00 Interest expense on Medicare 0 00 22.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory 0 \*\*\* Cost Center Deleted \*\*\* 23.00 23.00 A-8-3 65.00 therapy costs in excess of limitation (chapter 14) Adjustment for physical 24.00 A-8-3 OPHYSICAL THERAPY 66.00 24.00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review -OUTILIZATION REVIEW-SNF 114.00 25.00 physicians' compensation (chapter 21) Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 26.00 1.00 0 26, 00 COSTS-BLDG & FIXT FI XT OCAP REL COSTS-BLDG & FIXT 26.01 Depreciation - CAP REL 1.01 26.01 COSTS-BLDG & FLXT NON HOSP. NON HOSP 27. 00 Depreciation - NEW CAP REL ONEW CAP REL COSTS-MVBLE 2.00 27.00 COSTS-MVBLE EQUIP EQUI P 0 \*\*\* Cost Center Deleted \*\*\* 28.00 Non-physician Anesthetist 19.00 28.00 Physicians' assistant 29.00 29 00 0.00 Adjustment for occupational A-8-3 0 \*\*\* Cost Center Deleted \*\*\* 67.00 30.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30 99 OADULTS & PEDIATRICS 30 00 30.99

instructions)

From 09/01/2014 08/31/2015 Date/Time Prepared: 1/28/2016 9:46 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 31.00 Adjustment for speech 0 \*\*\* Cost Center Deleted \*\*\* 31. 00 A-8-3 68.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Α -308, 640 NEW CAP REL COSTS-MVBLE 2.00 11 32.00 Depreciation and Interest EQUI P 60, 444 I NTEREST EXPENSE 33.00 INTEREST EXPENSE 113.00 33.00 Α HEALTHLINK FEES - HOSPITAL HEALTHLINK FEES - RHC WHITE 13, 905 ADMINISTRATIVE & GENERAL 0 33.01 Δ 5.00 33.01 34.00 Α 1, 294 RURAL HEALTH CLINIC 88.00 34.00 HALL 36.00 INTEREST EXPENSE - MEDICARE -31, 183 ADMI NI STRATI VE & GENERAL 5.00 36.00 Α -20, 424 ADMI NI STRATI VE & GENERAL 37.00 RENTAL INCOME 37.00 5.00 В ol 38.00 COUNTY HH -51, 022 PHYSI CAL THERAPY 38.00 Α 66.00 39.00 GOODWILL AMORTIZATION -5, 472 NEW CAP REL COSTS-BLDG & 1.00 39.00 Α FLXT 40.01 0.00 40.01 42.00 MISC. INC. -2, 196 ADMI NI STRATI VE & GENERAL 0 42.00 В 5.00 44.00 0.00 44.00 44.01 44.01 0 0.00 44.02 0 0.00 44.02 MISC. INC. -350 LABORATORY 60.00 44.03 44.03 В 44.04 MISC. INC В -1, 273 AMBULANCE SERVICES 95.00 44.04 HEALTH FAIR -7, 216 ADMINISTRATIVE & GENERAL 44.05 44.05 В 5.00 IHA LOBBYING DUES -3, 212 ADMI NI STRATI VE & GENERAL 5.00 44.06 44 06 В 0 -353, 196 AMBULANCE SERVICES AMBULANCE SUBSIDY - OPERATIONS 45.00 В 95.00 45.00 45.01 CPSI TRAVEL Α -106, 515 ADMINISTRATIVE & GENERAL 5.00 45.01 46.00 MEDICAID ASSESSMENT TAX Α -79, 151 ADMINI STRATI VE & GENERAL 5.00 46.00 TOTAL (sum of lines 1 thru 49) -1, 133, 878 50 00 50.00 (Transfer to Worksheet A,

column 6, line 200.)

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

<sup>(2)</sup> Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 141300 

					1	To 08/31/2015	5   Date/Time Pro 1/28/2016 9:4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l 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	91. 00	EMERGENCY	932, 887		774, 310	0	0	1. 00
2.00	60.00	LABORATORY	6, 000	0	6, 000	0	0	2. 00
3.00	69. 00	ELECTROCARDI OLOGY	27, 497	27, 497	0	0	0	3. 00
4.00	0.00		0	0	0	0	0	4. 00
5.00	0.00		0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6.00
7.00	0. 00		0	0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	8. 00
9. 00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			966, 384	186, 074	780, 310	_	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er		Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8.00	9.00	12. 00	13.00	14.00	
1.00	91. 00	EMERGENCY	0	0	0	0	0	1. 00
2.00	60.00	LABORATORY	0	0	0	0	0	2. 00
3.00	69. 00	ELECTROCARDI OLOGY	0	0	0	0	0	3. 00
4.00	0.00		0	0	0	0	0	4. 00
5.00	0.00		0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0. 00		0	l 0	0	0	l 0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance	,		
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	91. 00	EMERGENCY	0	0	0	158, 577		1. 00
2.00	60.00	LABORATORY	0	0	0	0		2. 00
3.00	69. 00	ELECTROCARDI OLOGY	0	0	0	27, 497		3. 00
4.00	0.00		0	0	0	0		4. 00
5.00	0.00		0	0	0	0		5. 00
6.00	0. 00		0	0	0	0		6. 00
7. 00	0. 00		0	0	0	0		7. 00
8.00	0.00		0	1 0	0	i o		8. 00
9. 00	0.00		l o	Ö	0	i n		9. 00
10. 00	0.00		l o	-		n		10.00
200.00	0.00		0	-	-	186, 074		200.00
200.00	ı		'	'	1	1 .55, 67 1	I	00.00

	IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provi der C	CN: 141300	Peri od: From 09/01/2014 To 08/31/2015		pared:				
					Occupati onal Therapy	Cost					
						1. 00					
. 00	PART I - GENERAL INFORMATION  Total number of weeks worked (excluding aide:	s) (see instructi	ons)			52	1.00				
2. 00 3. 00	Line 1 multiplied by 15 hours per week  Number of unduplicated days in which supervi	eor or theranist	was on provid	ar sita (sa	a instructions)	780 124	ı				
1. 00	Number of unduplicated days in which therapy	assistant was or				0	1				
5. 00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe		oists (see ins	tructions)		0	5.0				
o. 00	Number of unduplicated offsite visits - there assistant and on which supervisor and/or the					0	6.0				
	instructions)	aprist was not pr	escite during	the visit(s	)) (3cc						
7. 00 3. 00	Standard travel expense rate Optional travel expense rate per mile					5. 52 0. 00					
		Supervi sors 1.00	Therapi sts 2.00	Assi stants	Ai des 4.00	Trai nees 5.00					
9. 00	Total hours worked	0. 00	211. 25	0.	0.00	0.00					
0.00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0. 00 35. 43	70. 85 35. 43	53. 26.		0. 00	10.00				
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)										
	Number of travel hours (provider site)	o	91		0		12.0				
2. 01 3. 00	Number of travel hours (offsite) Number of miles driven (provider site)	0 0	0		0		12. 0 13. 0				
3. 01	Number of miles driven (offsite)	0	0		0		13. 0				
						1. 00					
4. 00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1	line 10)				0	   14. C				
5. 00 6. 00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					14, 967 0	15. 0 16. 0				
7. 00	Subtotal allowance amount (sum of lines 14 am		ntory therapy	or lines 14	-16 for all	14, 967					
8. 00	others) Aides (column 4, line 9 times column 4, line	10)				0	18. 0				
9. 00	Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 fo		orany or line	c 17 and 10	for all others)	0 14, 967	19. 0 20. 0				
.0. 00	If the sum of columns 1 and 2 for respiratory	therapy or colu	ımns 1-3 for pl	nysical the	rapy, speech path	nol ogy or	20.0				
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete	lines 21-23.				line 23					
21. 00	Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3,			of columns	1 and 2, line 9	70. 85	21.0				
22. 00	Weighted allowance excluding aides and train Total salary equivalency (see instructions)					55, 263 55, 263					
23.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	VANCE AND TRAVEL	EXPENSE COMPU	TATION - PR	OVI DER SITE	55, 265	23.0				
24. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					4, 393	24.0				
25. 00 26. 00	Assistants (line 4 times column 3, line 11)	sum of lines 24	and 25 for al	Lothors)		0 4, 393					
27. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				3 and 4 for all	684					
28. 00	others) Total standard travel allowance and standard	travel expense a	nt the provide	r site (sum	of lines 26 and	5, 077	28. 0				
	27) Optional Travel Allowance and Optional Travel	Expense									
29. 00	Therapists (column 2, line 10 times the sum	of columns 1 and	2, line 12 )			6, 447	1				
30. 00 31. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or	,	and 30 for al	l others)		0 6, 447					
32. 00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	s 1 and 2, line 1	3 for respira	tory therap	y or sum of	0	32. 0				
3. 00	Standard travel allowance and standard trave			21)		5, 077					
34. 00 35. 00	Optional travel allowance and standard travel Optional travel allowance and optional travel					7, 131 6, 447	1				
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense	ANCE AND TRAVEL E	XPENSE COMPUTA	ATION - SER	VICES OUTSIDE PRO	OVIDER SITE					
86. 00	Therapists (line 5 times column 2, line 11)					0					
	Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)					0	ı				
37. 00 38. 00	Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel		6)			0	39.0				
		EXPENSE				0	40.0				
38. 00 39. 00 40. 00	Therapists (sum of columns 1 and 2, line 12.		2, line 10)								
38. 00 39. 00	Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column		2, line 10)	Assistants (column 3, line 12.01 times column 3, line 10)							
8. 00 9. 00 0. 00 1. 00	Therapists (sum of columns 1 and 2, line 12.	n 3, line 10) m of columns 1-3,	line 13.01)	-6.11		0	42.0				

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS  Provider CCN: 141300 Period: From 09/01/2014 To 08/31/2015 Occupational Therapy  Workshee Parts I- 00cupational Therapy	VI e Prep	-3
	6 9: 46	
	Cost	
1.00		
45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45. 00
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)  Therapists Assistants Aides Trainees Total	0	46. 00
1.00 2.00 3.00 4.00 5.00		
PART V - OVERTIME COMPUTATION  47.00 Overtime hours worked during reporting 0.00 0.00 0.00 0.00	0.00	47. 00
period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	47.00
48.00 Overtime rate (see instructions) 0.00 0.00 0.00 0.00		48. 00
49.00 Total overtime (including base and overtime 0.00 0.00 0.00 0.00 0.00 0.00		49. 00
CALCULATION OF LIMIT		
50.00 Percentage of overtime hours by category 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	0. 00	50. 00
51.00 Allocation of provider's standard work year 0.00 0.00 0.00 0.00 for one full-time employee times the percentages on line 50) (see instructions)	0. 00	51. 00
DETERMINATION OF OVERTIME ALLOWANCE		
52.00 Adjusted hourly salary equivalency amount 70.85 53.14 0.00 0.00 (see instructions) 53.00 Overtime cost limitation (line 51 times line 0 0 0 0		52. 00 53. 00
53. 50 See this cost from (fine 3) this sine (5) 52) 54. 00 Maximum overtime cost (enter the lesser of 0 0 0 0		54. 00
line 49 or line 53) 55.00 Portion of overtime already included in 0 0 0		55. 00
hourly computation at the AHSEA (multiply line 47 times line 52)		00.00
56.00 Overtime allowance (line 54 minus line 55 - 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	56. 00
Tot air others.)		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
	5. 263	57. 00
58.00 Travel allowance and expense - provider site (from lines 33, 34, or 35))	5, 077	58. 00
59.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 60.00 Overtime allowance (from column 5, line 56)	0	59. 00 60. 00
61. 00 Equipment cost (see instructions)	0	61.00
62.00 Supplies (see instructions)	0	62.00
		63. 00
		64. 00 65. 00
65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero)  LINE 33 CALCULATION	U	65.00
100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		100. 00
100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		100. 01
100.02 Line 33 = line 28 = sum of lines 26 and 27  LINE 34 CALCULATION	5, 0//	100. 02
101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	684	101. 00
		101. 01 101. 02
		102. 00 102. 01
13 for all others		102. 02

Health Financial Systems	THOMAS H BOYD CRITICAL	ACC HOSPITAL	In Lie	u of Form CMS-2552-10
REASONABLE COST DETERMINATION FOR OUTSIDE SUPPLIERS	THERAPY SERVICES FURNISHED BY	Provi der CCN: 141300	From 09/01/2014	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/28/2016 9:46 am
			Speech Pathology	Cost

		Date/Time Pre 1/28/2016 9:4 Cost					
				1-	peech Pathology	1. 00	
	PART I - GENERAL INFORMATION						
1. 00 2. 00 3. 00 4. 00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis Number of unduplicated days in which therapy nor therapist was on provider site (see inst		3 45 9 0	2. 00 3. 00			
5. 00 6. 00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - there assistant and on which supervisor and/or there instructions)	rvisors or ther apy assistants	(include only	visits made by		0	
7. 00 8. 00	Standard travel expense rate Optional travel expense rate per mile	5. 52 0. 00	1				
		Supervi sors 1.00	Therapi sts 2.00	Assi stants 3.00	Ai des 4. 00	Trai nees 5. 00	
9. 00	Total hours worked	0.00	14. 75	0.00			9. 00
10. 00 11. 00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0. 00 35. 43	70. 85 35. 43			0.00	10. 00 11. 00
12. 00 12. 01	Number of travel hours (provider site) Number of travel hours (offsite)	0	12 0	(			12. 00 12. 01
13. 00 13. 01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		) )		13. 00 13. 01
						1. 00	
14.00	Part II - SALARY EQUIVALENCY COMPUTATION	1: 10)				0	14.00
14. 00 15. 00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,					0 1, 045	
16. 00 17. 00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 au		ratory therapy	or lines 14-1	l6 for all	0 1, 045	
18. 00 19. 00	others) Aides (column 4, line 9 times column 4, line					0	
20. 00							20. 00
21. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3,	70. 85	21. 00				
22. 00 23. 00	Weighted allowance excluding aides and train. Total salary equivalency (see instructions)					3, 188 3, 188	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	VANCE AND TRAVE	L EXPENSE COMP	UTATION - PROV	/IDER SITE		
24. 00	Therapists (line 3 times column 2, line 11)					319	24. 00
25. 00	Assistants (line 4 times column 3, line 11)	oum of lines 2	4 and DE for a	II othoro)		0	
26. 00 27. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)			,	and 4 for all	319 50	
28. 00	Total standard travel allowance and standard 27)	travel expense	at the provid	er site (sum o	of lines 26 and	369	28. 00
29. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of		d 2 line 12 )			850	29. 00
30. 00	Assistants (column 3, line 10 times column 3,	line 12)				0	30.00
31. 00 32. 00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns)				or sum of	850 0	1
33. 00	columns 1-3, line 13 for all others) Standard travel allowance and standard travel					369	
34. 00 35. 00	Optional travel allowance and standard travel Optional travel allowance and optional travel					900 850	
33.00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense				CES OUTSIDE PRO		33.00
36.00	Therapists (line 5 times column 2, line 11)					0	
37. 00 38. 00	Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)					0	
39. 00	Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel		d 6)			0	
40.00	Therapists (sum of columns 1 and 2, line 12.0	01 times column	2, line 10)			0	
41. 00 42. 00	Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	is, iine IU)				0	
43. 00	Optional travel expense (line 8 times the sur Total Travel Allowance and Travel Expense - (			e of the follo	owing three line	oes 44, 45,	1
44. 00	or 46, as appropriate. Standard travel allowance and standard travel	expense (sum	of lines 38 an	d 39 - see ins	structions)	0	
45. 00	Optional travel allowance and standard travel	expense (sum	of lines 39 an	d 42 - see ins	structions)	0	45. 00

	<i></i>	AS H BOYD CRITIC				u of Form CMS-		
	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 141300	Peri od: From 09/01/2014 To 08/31/2015		pared:	
					Speech Pathology			
						1. 00		
46 00	Optional travel allowance and optional travel	expense (sum o	of lines 42 an	d 43 - see i	nstructions)		46. 00	
10.00	oper share traver arremance and oper share traver	Therapi sts	Assi stants	Ai des	Trai nees	Total	10.00	
		1.00	2. 00	3.00	4. 00	5. 00		
	PART V - OVERTIME COMPUTATION							
47. 00	Overtime hours worked during reporting	0. 00	0. 00	0.	0.00	0.00	47. 00	
	period (if column 5, line 47, is zero or							
	equal to or greater than 2,080, do not							
	complete lines 48-55 and enter zero in each							
48. 00	column of line 56) Overtime rate (see instructions)	0. 00	0.00	0.	0.00		48. 00	
49. 00	Total overtime (including base and overtime	0.00	0.00				49. 00	
47.00	allowance) (multiply line 47 times line 48)	0.00	0.00	0.	0.00		77.00	
	CALCULATION OF LIMIT						1	
50.00	Percentage of overtime hours by category	0. 00	0.00	0.	0.00	0.00	50. 00	
	(divide the hours in each column on line 47							
	by the total overtime worked - column 5,							
E4 00	line 47)	0.00	0.00		0.00		F4 00	
51. 00	Allocation of provider's standard work year for one full-time employee times the	0. 00	0. 00	0.	0.00	0.00	51. 00	
	percentages on line 50) (see instructions)							
	DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount	70. 85	0.00	0.	0.00		52. 00	
	(see instructions)							
53.00	Overtime cost limitation (line 51 times line	0	0		0		53. 00	
	52)							
54. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54. 00	
55. 00	Portion of overtime already included in	0	0		0 0		55. 00	
00.00	hourly computation at the AHSEA (multiply	J	· ·				00.00	
	line 47 times line 52)							
56. 00	Overtime allowance (line 54 minus line 55 -	0	0		0 0	0	56. 00	
	if negative enter zero) (Enter in column 5							
	the sum of columns 1, 3, and 4 for							
	respiratory therapy and columns 1 through 3 for all others.)							
	Tot all others.)							
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			1. 00		
57.00	Salary equivalency amount (from line 23)					3, 188		
58. 00	Travel allowance and expense - provider site					369	1	
59. 00	Travel allowance and expense - Offsite service	es (from lines	44, 45, or 46	)		0		
60.00	Overtime allowance (from column 5, line 56)					0		
61.00	Equipment cost (see instructions)					0		
62. 00 63. 00	Supplies (see instructions) Total allowance (sum of lines 57-62)					0 3, 557		
64. 00	Total cost of outside supplier services (from	vour recorde)					64. 00	
64.00 65.00	Fuer		1, 243	75.00				

	1. 00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00 Salary equivalency amount (from line 23)	3, 188	57. 00
58.00 Travel allowance and expense - provider site (from lines 33, 34, or 35))	369	58.00
59.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59. 00
60.00 Overtime allowance (from column 5, line 56)	0	60.00
61.00 Equipment cost (see instructions)	0	61. 00
62.00 Supplies (see instructions)	0	62.00
63.00 Total allowance (sum of lines 57-62)	3, 557	
64.00 Total cost of outside supplier services (from your records)	1, 245	64. 00
65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
LINE 33 CALCULATION		
100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		100.00
100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		100. 01
100.02 Line 33 = line 28 = sum of lines 26 and 27	369	100. 02
LINE 34 CALCULATION		
101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		101. 00
101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		101. 01
101.02 Line 34 = sum of lines 27 and 31	900	101. 02
LINE 35 CALCULATION		
102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		102. 00
102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line	0	102. 01
13 for all others	050	
102.02 Line 35 = sum of lines 31 and 32	850	102. 02

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 141300

Cast Center Resuription						10	08/31/2015	1/28/2016 9: 4	
PARTICIPATION   PIXE   PIXE   NOW HOSP.   EQUIP   DEPARTMENT   POTO BASE A   CO   CO   CO   CO   CO   CO   CO					CAPI	TAL RELATED CO	STS		
Company   Comp			Cost Center Description	for Cost Allocation (from Wkst A				BENEFITS	
0.0100   UNIT CAP PET LOSIS - BLUCA S FIXT   44, 359					1.00	1. 01	2. 00	4. 00	
1.01   1.07		GENER	AL SERVICE COST CENTERS						
2.00   0.0200   NEW CAP REL COSTS-MANUE EQUIP   159, 361   159, 361   2.00   0.	1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	44, 359	44, 359				1.00
0.000   DOMO   DIPLOYEE BENEFITS DEPARTMENT   007,071   0   0   0   0   970,071   4.00		1	l e e e e e e e e e e e e e e e e e e e	1	0	14, 443			
5.00     0.0500   ADMINISTRATIVE & GENERAL   1,701,363   5,436   1,676   672   8,226   7,00     8.00   0.0500   ADMINISTRATIVE   1,897   1,000   0.000   0.000   1,143   8,000     8.00   0.0500   ADMINISTRATIVE   1,897   1,897   1,000     8.00   0.0500   ADMINISTRATIVE   1,897   1,000   0.000   0.000   1,143   8,000     8.00   0.0500   ADMINISTRATIVE   1,897   1,897   1,000     8.00   0.0500   ADMINISTRATIVE   1,897   1,000   0.000   0.000   1,143   8,000     8.00   0.0500   ADMINISTRATIVE   1,897   1,897   1,000     8.00   0.0500   ADMINISTRATIVE   1,897   1,897   1,000     8.00   0.0500   ADMINISTRATIVE   1,897   1,897   1,997     8.00   0.0500   ADMINISTRATIVE   1,897   1,897   1,997     8.00   0.0500   ADMINISTRATIVE   1,897   1,897   1,997     8.00   0.0500   ADMINISTRATIVE   1,997   1,997     8.00   0.05		1	l e e e e e e e e e e e e e e e e e e e		_	_			
7.00   00700  OPERATION OF PLANT   205,896   1,020   0 672   8,226   7,000   0 0 0 0 0 17,124   8.00   0 0 0 0 0 0 12,434   0.00   0 0 0 0 0 0 12,434   0.00   0 0 0 0 0 0 12,434   0.00   0 0 0 0 0 0 12,434   0.00   0 0 0 0 0 0 0 12,434   0.00   0 0 0 0 0 0 0 12,434   0.00   0 0 0 0 0 0 0 0 0 12,434   0.00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1	-	-	9		
8.00   00800  AUBIORY & LINEN SERVICE   38.841   1,562   0   0   4.173   8.00   10.00   10.00   10.00   12.447   10.00   10.00   12.447   10.00   10.00   12.447   10.00   10.00   12.447   10.00   10.00   12.447   10.00   10.00   12.447   10.00   10.00   12.447   10.00   10.00   12.447   10.00   10.00   12.447   10.00   10.00   12.447   10.00   10.00   12.447   10.00   10.00   12.447   10.00   10.00   12.447   10.00   10.00   12.447   10.00   10.00   12.447   10.00   10.00   10.00   12.447   10.00									
9.00   00000   MOUSEKEPING   130,000   326   0   0   13,434   9,00   11.00   01000   OLTRAY   108,448   4,006   0   0   0   0   11.00   11.00   01000   OLTRAY   108,448   4,006   0   0   0   0   11.10   11.00   01000   OLTRAY   11.00   0   0   0   0   0   11.10   15.00   01000   OLTRAY   12,457   0   0   0   0   11.00   15.00   01000   OLTRAY   12,457   0   0   0   0   0   0   0   15.00   01000   OLTRAY   12,457   0   0   0   0   0   0   0   15.00   01000   OLTRAY   12,457   0   0   0   0   0   0   0   23.00   OLTRAY   12,457   0   0   0   0   0   0   0   0   23.00   OLTRAY   12,457   0   0   0   0   0   0   0   0   23.00   OLTRAY   12,457   0   0   0   0   0   0   0   0   0   23.00   OLTRAY   12,457   0   0   0   0   0   0   0   0   0				1	•		-		
10.00   01000   DETARY   108,448		1	l e e e e e e e e e e e e e e e e e e e	1			-1	•	
13.00   0.300   MURSIN SA ADMINISTRATION   131.305   0   0   17.124   13.00				1			o		
14.00   01400 (PENTRAL SERVICES & SUPPLY   87, 732   875   0   0   3,776   14.00   15.00   15.00   15.00   16.00   MEDICAL RECORDS & LIBRARY   132,730   1,143   0   292   17,928   16.00   0   0   0   23.0				0			0	-	
15.00   01500   PHARMACY   214, 967   001   0   0   0   15.00   0   23.00   0300   PHARMACY   132, 730   1,145   0   0   0   0   0   0   23.00   0   0   0   0   0   0   23.00   0   0   0   0   0   0   0   23.00   0   0   0   0   0   0   0   23.00   0   0   0   0   0   0   0   23.00   0   0   0   0   0   0   0   0   0				1			0		
1.00   01000   MEDICAL RECORDS & LIBRARY   132,730   1,145   0   292   17,928   16,00   023,00   03000   040000   040000   040000   040000   040000   040000   040000   040000   0400000   0400000				1		0	0		
DATE OF PARAMED ED PROM   0   0   0   0   0   23.00		1	l .	1		0	292		
INPATI ENT ROUTINE SERVICE COST CENTERS   1,133,597   13,878   0   10,731   139,575   30 0 0   00 0 0   00   00   00   00				1					
0.000   04000   SUBPROVI DER - I PF						· · · · · · · · · · · · · · · · · · ·	- 1		
11 00   04100 SUBPROVIDER - IRF				1, 133, 597			10, 731		
42 00   04200   NURSING FACILITY		1	l .	0		-	-1	-	
		1	l .	0			0	-	
ANCILLARY SERVICE COST CENTERS   54. 00   57. 00   61.007   49.240   54. 00   57. 00   57.00   67.00							0	-	
57.00   05700   CT SCAN   0   0   0   0   0   0   57.00	10.00			<u> </u>		<u> </u>	<u> </u>		10.00
58.00   05800   MACHTIC RESONANCE IMAGINC (NRI)   0   0   0   0   0   58.00	54.00			554, 860	2, 717	0	61, 007	49, 240	54. 00
99 00   05900   CARDIA C CATHETERIZATION   0   0   0   0   0   0   59 00		1		0			0	-	
60.00   0.0000   LABORATORY				0	-		0	-	
COLOR   DOCOD   BADDRATORY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				604 962	-		1 826	-	
Color   Colo		1	l e e e e e e e e e e e e e e e e e e e	074, 702		1			
64.00   06400   INTRAVENDUS THERAPY   0   0   0   0   0   64.00		1	l e e e e e e e e e e e e e e e e e e e	O			Ö	-	
66.00   06600   PHYSICAL THERAPY   270,535   2,295   0   9,100   36,448   66.00   06.00   06.00   LECTROCARDIOLOGY   18,448   0   0   0   0   0   2,430   69,00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   71.00   71.00   71.30   07101   MIPL. DEV. CHARGED TO PATIENT   0   0   0   0   0   0   0   0   72.00   72.00   73.00   07200   IMPL. DEV. CHARGED TO PATIENT   0   0   0   0   0   0   0   0   0				6, 823	0	0	O	68	
69.00   06900   ELECTROCARDI OLOGY   18,448   0   0   0   2,430   69,00				0	-	-	0	-	
17.1 00		1	l .	1	•	1	9, 160		
77.3 0   07101   IMPL DEV. CHARGED TO PATIENT   0   0   0   0   0   0   0   71. 30   72. 00   77.200   IMPL DEV. CHARGED TO PATIENT   0   0   0   0   0   0   0   73. 00   73. 00   73. 00   073. 00				10, 440	-	-	0		
172.00   07200   IMPL DEV. CHARGED TO PATIENT   0   0   0   0   0   0   72.00					0	l o	o	-	
76. 00	72.00			o	0	0	o	0	72. 00
Name				0			0		
88. 00   08800 RURAL HEALTH CLINIC	76. 00			] 0	0	0	0	0	76. 00
89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER	88 00			1 322 014	2 339	Ο	35 082	164 237	88 00
90. 00   99000   CLINIC   6, 263   236   0   0   846   90. 00   91. 00   91. 00   91. 00   91. 00   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   92. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   93. 00   04050   TELEMEDICINE   0   0   0   0   0   0   0   0   0				0			· · ·		
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   0   93. 00   93. 00   04050   TELEMEDI CI NE   0   0   0   0   0   0   93. 00   075. 00   09500   AMBULANCE SERVI CES   110, 951   666   0   0   51, 035   98. 00   09851   OTHER REI MBURSABLE COST CENTERS   0   0   0   0   0   0   98. 00   99. 10   09910   CORF   0   0   0   0   0   0   0   0    SPECI AL PURPOSE COST CENTERS   0   0   0   0   0   0   0   110. 00   10000   PANCREAS ACQUI SI TI ON   0   0   0   0   0   0   111. 00   11100   I SLET ACQUI SI TI ON   0   0   0   0   0   0   113. 00   1300   INTEREST EXPENSE   113. 00   114. 00   11400   UTI LI ZATI ON REVI EW-SNF   114. 00   115. 00   106951   OTHER SPECI AL PURPOSE COST CENTERS   0   0   0   0   0   117. 00   118. 00   SUBTOTALS (SUM OF LINES 1-117)   9, 444, 075   44, 080   1, 764   159, 361   900, 181   190. 00   193. 00   19300   NONPAI D WORKERS   0   0   0   0   0   0   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   190. 00   191. 00   191. 00   191. 00   192. 00   190. 00   191. 00   191. 00   191. 00   194. 00   07951   OTHER ROMERIAS BLE COST CENTERS   52, 478   279   12, 679   0   6, 890   194. 00   201. 00   Nogati ve Cost Centers   0   0   0   0   0   201. 00   Nogati ve Cost Centers   0   0   0   0   0   201. 00   Nogati ve Cost Centers   0   0   0   0   201. 00   Nogati ve Cost Centers   0   0   0   0   201. 00   Nogati ve Cost Centers   0   0   0   0   201. 00   190. 00   190. 00   0   0   0   201. 00   190. 00   190. 00   0   0   201. 00   190. 00   190. 00   0   0   201. 00   190. 00   190. 00   0   0   201. 00   190. 00   190. 00   0   0   201. 00   190. 00   190. 00   0   0   201. 00   190. 00   190. 00   0   0   201. 00   190. 00   190. 00   0   0   201. 00   190. 00   190. 00   0   0   201. 00   190. 00   190. 00   0   200. 00   190. 00   190. 00   0   200. 00   190. 00   190. 00   200. 00   190. 00   190. 00   190. 00   200. 00   190. 00   190. 00   190. 00   200. 00   190. 00   190. 00   190. 00   200. 00   190. 00   190. 00   200. 00   190.	90.00			6, 263	236	О	О	846	90. 00
93. 00   04050   TELEMEDI CINE   0   0   0   0   0   0   93. 00				1, 389, 046	4, 333	0	1, 939	172, 386	
OTHER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   0 0 0 0 0 0 0 0 0 98. 00					0			0	
95. 00	93.00			l ol	0	l U	U <sub>I</sub>	0	93.00
99. 10	95. 00			110, 951	666	0	0	51, 035	95. 00
SPECIAL PURPOSE COST CENTERS   109, 00 10900   PANCREAS ACQUISITION   0 0 0 0 0 0 0 0 109, 00   110, 00 110, 00 110, 00 110, 00 110, 00 110, 00 110, 00 110, 00 110, 00 110, 00 111, 00 110, 00 111,	98. 00	09851	OTHER REIMBURSABLE COST CENTERS	1	0	0	О		98. 00
109. 00	99. 10			0	0	0	0	0	99. 10
110.00   11000   INTESTINAL ACQUISITION   0   0   0   0   0   0   1110.00     111.00   11100   ISLET ACQUISITION   0   0   0   0   0   0     111.00   11100   ISLET ACQUISITION   0   0   0   0   0     113.00   11300   INTEREST EXPENSE   113.00     114.00   11400   UTI LI ZATI ON REVI EW-SNF   114.00     115.00   11500   AMBULATORY SURGI CAL CENTER (D. P.)   0   0   0   0   0   0     117.00   11500   O6951   OTHER SPECIAL PURPOSE COST CENTERS   0   0   0   0   0     118.00   SUBTOTALS (SUM OF LINES 1-117)   9,444,075   44,080   1,764   159,361   900,181     118.00   NONREI MBURSABLE COST CENTERS   0   0   0   0   0     19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0     191.00   19300   NONPAID WORKERS   0   0   0   0   0     193.00   19300   NONPAID WORKERS   0   0   0   0     194.00   07951   OTHER NONREI MBURSABLE COST CENTERS   52,478   279   12,679   0   6,890   194.00     200.00   Cross Foot Adjustments   200.00     201.00   Negati ve Cost Centers   0   0   0   0   0     201.00   Ogati ve Cost Centers   0   0   0   0      10.00   110.00   0   0   0     111.00   0   0   0   0     111.00   0   0   0   0     111.00   0   0   0   0     111.00   0   0   0   0     111.00   0   0   0   0     111.00   0   0   0   0     111.00   0   0   0   0     111.00   0   0   0   0     111.00   0   0   0   0     111.00   0   0   0   0     111.00   0   0   0     111.00   0   0   0   0     111.00   0   0   0   0     111.00   0   0   0     111.00   0   0   0     111.00   0   0   0     111.00   0   0   0     111.00   0   0   0     111.00   0   0   0     111.00   0   0   0     111.00   0   0   0     111.00   0   0   0     111.00   0   0     111.00   0   0   0   0     111.00   0   0     111.00   0   0   0     111.00   0   0   0     111.00   0   0   0     111.00   0   0   0     111.00   0   0   0     111.00   0   0   0     111.00   0   0   0     111.00   0   0   0     111.00   0   0   0   0     111.00   0   0   0   0     111.00   0   0   0     111.00   0   0   0   0     111.00   0   0   0     111.00   0   0   0   0	100.00						ما	0	100.00
111. 00				0			- 1		
113. 00		1	l e e e e e e e e e e e e e e e e e e e		0		0		
115. 00					3		Ĭ	· ·	
117. 00 06951 OTHER SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 117. 00  118. 00 SUBTOTALS (SUM OF LINES 1-117) 9, 444, 075 44, 080 1, 764 159, 361 900, 181 118. 00  NONREI MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 190. 00  191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00  193. 00 19300 NONPAID WORKERS 0 0 0 0 0 0 191. 00  194. 00 07951 OTHER NONREI MBURSABLE COST CENTERS 52, 478 279 12, 679 0 6, 890 194. 00  200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									
118. 00   SUBTOTALS (SUM OF LINES 1-117)   9,444,075   44,080   1,764   159,361   900,181   118.00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190. 00   191. 00   193. 00   19300   NONPAI D WORKERS   0   0   0   0   0   0   193. 00   193. 00   194. 00   07951   OTHER NONREI MBURSABLE COST CENTERS   52,478   279   12,679   0   6,890   194. 00   200. 00   0   0   0   0   0   0   0   0				0	0	0	0		
NONRE   MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190. 00     191. 00   19100   RESEARCH   0   0   0   0   0   191. 00     193. 00   19300   NONPAI D   WORKERS   0   0   0   0   0   0     194. 00   07951   OTHER NONREI MBURSABLE COST CENTERS   52, 478   279   12, 679   0   6, 890   194. 00     200. 00   Cross Foot Adjustments   200. 00   201. 00     201. 00   Negative Cost Centers   0   0   0   0   201. 00     202. 00   0   0   0   0   0   0     203. 00   0   0   0   0     204. 00   0   0   0   0     205. 00   0   0   0   0     206. 00   0   0   0     206. 00   0   0   0     207. 00   0   0   0     208. 00   0   0   0     208. 00   0   0     209. 00   0   0     209. 00   0   0     209. 00   0   0     209. 00   0   0     209. 00   0   0     209. 00   0     209. 00   0     209. 00   0     209. 00   0     209. 00   0     209. 00   0     209. 00   0     209. 00   0     209. 00   0     209. 00   0     209. 00   0     209. 00   0     209. 00   0     209. 00   0     209. 00     209. 00   0     209. 00			l e e e e e e e e e e e e e e e e e e e	0 444 075	44.090	1 744	150 241		
190. 00     19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN     0     0     0     0     0     190. 00       191. 00     19100 RESEARCH     0     0     0     0     0     191. 00       193. 00     19300 NONPAID WORKERS     0     0     0     0     0     0     193. 00       194. 00     07951 OTHER NONREI MBURSABLE COST CENTERS     52, 478     279     12, 679     0     6, 890     194. 00       200. 00     Cross Foot Adjustments     200. 00       201. 00     Negative Cost Centers     0     0     0     0     0     201. 00	110.00			9, 444, 075	44, 060	1, 704	139, 301	900, 161	116.00
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 194. 00 07951 OTHER NONREI MBURSABLE COST CENTERS 52, 478 279 12, 679 0 6, 890 194. 00 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 201. 00	190.00			0	0	0	0	0	190. 00
194. 00 07951 OTHER NONREIMBURSABLE COST CENTERS 52, 478 279 12, 679 0 6, 890 194. 00 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 201. 00	191.00	19100	RESEARCH	0	0	0	o	0	191. 00
200.00   Cross Foot Adjustments   200.00   201.00   Negative Cost Centers   0   0   0   201.00		1	l e e e e e e e e e e e e e e e e e e e	0	-	-	O		
201.00   Negative Cost Centers   0 0 0 201.00			l e e e e e e e e e e e e e e e e e e e	52, 478	279	12, 679	O	6, 890	
		1			Λ	n	n	Λ	
		1	1 0	9, 496, 553	44, 359	14, 443	159, 361		
				·		·	·		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141300

					1/28/2016 9: 4	6 am
Cost Center Description	Subtotal	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	PLANT	LINEN SERVICE		
	4A	5. 00	7. 00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT					ı	1.00
1.01 O0101 CAP REL COSTS-BLDG & FIXT NON HOSP.					ı	1. 01
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP					ı	2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					ı	4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	1, 891, 112	1, 891, 112			ı	5. 00
7. 00   00700   OPERATION OF PLANT	216, 420		l .		ı	7. 00
			1		ı	
8. 00   00800 LAUNDRY & LINEN SERVICE	44, 576		l		407.040	8. 00
9. 00   00900   HOUSEKEEPI NG	143, 760		l		186, 313	9. 00
10. 00  01000  DI ETARY	194, 469		31, 286	416	7, 977	10. 00
11. 00  01100 CAFETERI A	0	0	0	0	0	11. 00
13.00 O1300 NURSING ADMINISTRATION	148, 489	36, 922	0	0	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	92, 383	22, 971	6, 397	0	0	14.00
15. 00 01500 PHARMACY	215, 568	53, 602	1		0	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	152, 095		1		199	16. 00
23. 00   02300   PARAMED ED   PRGM	102,070		1		0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1	<u> </u>	0	23.00
	1 207 701	222 (07	101 407	22.040	115 204	20.00
30. 00   03000   ADULTS & PEDI ATRI CS	1, 297, 781	322, 697	1	33, 948	115, 284	30.00
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
45.00 04500 NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS	<u>`</u>		•			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	667, 824	166, 056	19, 863	4, 191	8, 120	54.00
57. 00   05700   CT   SCAN	007,021	100,000	1 .,, 556	., . , .	0, 120	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0				0	58. 00
	0	0		U		
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0			0	0	59. 00
60. 00   06000   LABORATORY	752, 170	187, 029	10, 516	0	8, 220	60.00
60. 01  06001 BL00D LABORATORY	0	0	0	0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	6, 891	1, 713	0	ol	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	1	0	0	0	64. 00
66. 00   06600   PHYSI CAL THERAPY	318, 438	79, 181	16, 773	3, 886	829	66. 00
			10,773	3,000	027	
	20, 878	5, 191		U		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0	0	71. 00
71.30 O7101 MPL. DEV. CHARGED TO PATLENT	0	0	0	0	0	71. 30
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	o	0	73.00
76. 00 03030 ANGI OCARDI OGRAPHY	0	1 0	0	ol	0	76. 00
OUTPATIENT SERVICE COST CENTERS		-		-1		
88. 00 08800 RURAL HEALTH CLINIC	1, 523, 672	378, 866	17, 096	101	30, 194	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	1, 323, 072		17,070		0	89. 00
	_	-	1	٩		
90. 00   09000   CLI NI C	7, 345		1		0	90. 00
91. 00  09100 EMERGENCY	1, 567, 704	389, 813	31, 670	12, 656	12, 098	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				ı	92. 00
93. 00  04050  TELEMEDICINE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	162, 652	40, 444	4, 870	7, 392	199	95.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	1	0	0	0	
99. 10   09910   CORF	Ö				0	99. 10
SPECIAL PURPOSE COST CENTERS			1	<u> </u>	U	77. 10
109. 00 10900 PANCREAS ACQUISITION		1	J	١	0	109. 00
	0	•	_	_		
110.00 11000 I NTESTI NAL ACQUI SI TI ON	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 I NTEREST EXPENSE					ı	113.00
114.00 11400 UTILIZATION REVIEW-SNF					i	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	l o	0	ol	0	115. 00
117. 00 06951 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0		117. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	9, 424, 227	1, 873, 128	268, 191	67, 015	183, 120	
NONREI MBURSABLE COST CENTERS	7,424,221	1,0/3,120	200, 191	07,013	103, 120	110.00
					^	100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1	0			190.00
191. 00 19100 RESEARCH	0	0	y 0	0		191. 00
193. 00 19300 NONPALD WORKERS	0	0	1 0	0		193. 00
194.00 07951 OTHER NONREIMBURSABLE COST CENTERS	72, 326	17, 984	2, 042	60	3, 193	194. 00
200.00 Cross Foot Adjustments	0				i	200. 00
201.00 Negative Cost Centers	0	0	0	o	0	201. 00
202.00 TOTAL (sum lines 118-201)	9, 496, 553	1, 891, 112	270, 233	67, 075		
1.2 (22 1.1100 1.10 201)	., ., ., 5, 500	., 0, ., 112	2,0,200	0.,070	.55, 510	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141300

				10	06/31/2015	1/28/2016 9: 4	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	
		10.00	11. 00	13. 00	SUPPLY 14.00	15. 00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	13.00	
1. 00 1. 01 2. 00 4. 00 5. 00 7. 00 8. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT NON HOSP. 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						1. 00 1. 01 2. 00 4. 00 5. 00 7. 00 8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	282, 503					9. 00 10. 00
11. 00	01100 CAFETERI A	200, 154	200, 154				11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	3, 921	189, 332	104 207		13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	2, 546	0	124, 297	273, 560	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	7, 689	0	0	273, 300	16. 00
23. 00	02300 PARAMED ED PRGM	0	0	0	o	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	82, 349	51, 026	126, 852 0	0	0	30.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0	0	0	0	40. 00 41. 00
42. 00	04200 SUBPROVI DER		0	Ö	ő	0	42. 00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	0	17, 314	0	0	0	54.00
57. 00 58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0	0	0	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0	l ő	ő	0	59. 00
60.00	06000 LABORATORY	0	20, 700	0	О	0	60. 00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	0	0	0	63. 00 64. 00
66. 00	06600 PHYSI CAL THERAPY		12, 527	0	0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	o	0	Ö	Ö	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	124, 297	0	71. 00
71. 30	07101 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71. 30
72.00	07200 DRUCS CHARGED TO PATIENT	0	0	0	0	272 540	72. 00 73. 00
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03030 ANGI OCARDI OGRAPHY		0	0	0	273, 560 0	76.00
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u> </u>	o <sub>l</sub>		70.00
88. 00	08800 RURAL HEALTH CLINIC	0	22, 559	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 91. 00	09000 CLINIC	0	306	(2.400	0	0	90.00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	36, 690	62, 480	U U	U	91. 00 92. 00
93. 00	04050 TELEMEDICINE	O	0	0	o	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	22, 279		0	0	95. 00
98. 00 99. 10	09851 OTHER REIMBURSABLE COST CENTERS   09910   CORF	0	0	0	0	0	98. 00 99. 10
77. 10	SPECIAL PURPOSE COST CENTERS	ı o	0	<u> </u>	υ <sub>l</sub>	0	77. 10
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
	11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
	11100   SLET ACQUI SITI ON	0	0	0	0	0	111.00
	11300   INTEREST EXPENSE 11400   UTI LI ZATI ON REVI EW-SNF						113. 00 114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
	06951 OTHER SPECIAL PURPOSE COST CENTERS	Ö	0	Ō	ō		117. 00
118. 00		282, 503	197, 557	189, 332	124, 297	273, 560	118. 00
400.00	NONREI MBURSABLE COST CENTERS				ما		100.00
	) 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN ) 19100 RESEARCH	0	0	0	0		190. 00 191. 00
	19300 NONPALD WORKERS		0	0	0		193. 00
	07951 OTHER NONREIMBURSABLE COST CENTERS		2, 597	O	Ö		194. 00
200.00							200. 00
201.00		0	0	100 222	0		201.00
202.00	TOTAL (sum lines 118-201)	282, 503	200, 154	189, 332	124, 297	273, 560	<sub>1</sub> 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 THOMAS H BOYD CRITICAL ACC HOSPITAL Worksheet B Part I Date/Time Prepared: 1/28/2016 9: 46 am Provi der CCN: 141300 Peri od: From 09/01/2014 To 08/31/2015 MEDI CAL RECORDS & LI BRARY Intern & Residents Cost Cost Center Description PARAMED ED Subtotal Total PRGM & Post Stepdown Adjustments

		16.00	23. 00	24. 00	25. 00	26. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1. 01 2. 00	00101 CAP REL COSTS-BLDG & FIXT NON HOSP. 00200 NEW CAP REL COSTS-MVBLE EQUIP						1. 01 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG						9. 00 10. 00
11. 00	01000 DI ETARY 01100 CAFETERI A						11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	206, 171					16. 00
23. 00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	O				23. 00
30. 00	03000 ADULTS & PEDIATRICS	56, 013	0	2, 187, 386	0	2, 187, 386	30.00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	O	0	40. 00
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	0	
42.00	04200 SUBPROVI DER	0	0	0	0	0	
45. 00	04500 NURSING FACILITY ANCILLARY SERVICE COST CENTERS	<u> </u>	0	0	0	0	45. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	29, 024	0	912, 392	O	912, 392	54. 00
57. 00	05700 CT SCAN	0	Ö	0	Ö	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	34, 063	0	1, 012, 698	0	1, 012, 698	•
60. 01 62. 00	06001 BLOOD LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	60. 01 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	8, 604	0	8, 604	1
64. 00	06400 I NTRAVENOUS THERAPY	Ö	Ö	0	Ö	0	64. 00
66. 00	06600 PHYSI CAL THERAPY	3, 876	0	435, 510	0	435, 510	
69. 00	06900 ELECTROCARDI OLOGY	0	0	26, 069	0	26, 069	1
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	124, 297	0	124, 297	1
71. 30 72. 00	07101 IMPL. DEV. CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	273, 560	0	273, 560	•
76. 00	03030 ANGI OCARDI OGRAPHY	0	0	0	0	0	•
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	25, 390	0	1, 997, 878	0	1, 997, 878	1
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	0 11, 205	0	0 11, 205	89. 00 90. 00
91. 00	09100 EMERGENCY	52, 427	0	2, 165, 538	0	2, 165, 538	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	,		_,,	O	_,,	92.00
93. 00	04050 TELEMEDI CI NE	0	0	0	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS			0.40 770	اء	0.40 770	
95. 00 98. 00	09500 AMBULANCE SERVICES 09851 OTHER REIMBURSABLE COST CENTERS	4, 942 0	0	242, 778 0	0	242, 778 0	95. 00 98. 00
99. 10	09910 CORF	0	0	0	0	0	99. 10
,,,,,	SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>		/// 10
	10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
	11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
	11100   SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
	11300 INTEREST EXPENSE 11400 UTI LI ZATI ON REVI EW-SNF						113. 00 114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
	06951 OTHER SPECIAL PURPOSE COST CENTERS	Ö	Ö	0	Ö		117. 00
118.00		205, 735	0	9, 397, 915	0	9, 397, 915	118. 00
100 0	NONREI MBURSABLE COST CENTERS	_T	=1	-	_T	_	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19100 RESEARCH   19300 NONPAI D WORKERS	0	0	0	0		191. 00 193. 00
	07951 OTHER NONREIMBURSABLE COST CENTERS	436	0	98, 638	ol		194. 00
200.00			0	0	o		200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	206, 171	0	9, 496, 553	0	9, 496, 553	202. 00

Health Financial Systems THOMAS H BOYD CRITICAL ACC HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 141300 Peri od: Worksheet B From 09/01/2014 Part II Date/Time Prepared: To 08/31/2015 1/28/2016 9:46 am CAPITAL RELATED COSTS Cost Center Description Directly NEW BLDG & BLDG & FIXT NEW MVBLE Subtotal Assigned New FIXT NON HOSP. **FOULP** Capi tal Related Costs 1.00 1.01 2.00 2A 0 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT NON HOSP. 1.01 1.01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 45, 852 5 00 0 0 5 436 38 652 5 00 1.764 00700 OPERATION OF PLANT 7.00 1,626 0 672 2, 298 7.00 1, 562 8.00 00800 LAUNDRY & LINEN SERVICE 1, 562 0 8.00 00900 HOUSEKEEPI NG 0 0 0 0 326 9.00 9 00 326 01000 DI ETARY 0 10.00 4,606 0 4,606 10.00 11.00 01100 CAFETERI A 0 11.00 01300 NURSING ADMINISTRATION 13.00 0 0 0 0 13.00 0 01400 CENTRAL SERVICES & SUPPLY 0 875 0 875 14 00 14 00 15.00 01500 PHARMACY 601 0 0 601 15.00 01600 MEDICAL RECORDS & LIBRARY 0 0 292 1, 437 16.00 1, 145 16.00 02300 PARAMED ED PRGM 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 13, 878 0 10, 731 24, 609 30.00 04000 SUBPROVIDER - IPF 0 0 40.00 40.00 0 04100 SUBPROVIDER - IRF 0 0 0 41.00 41.00 0 0 04200 SUBPROVI DER 42.00 C 0 0 42 00 04500 NURSING FACILITY 0 45.00 45.00 0 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 0 61, 007 54.00 2. 717 0 63, 724 54.00 0 0 57.00 05700 CT SCAN 0 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 58.00 0000000 0 0 0 05900 CARDIAC CATHETERIZATION 59.00 0 59.00 0 06000 LABORATORY 0 3, 265 60.00 60.00 1, 439 1,826 0 60.01 06001 BLOOD LABORATORY 60.01 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. C 0 0 0 63.00 06400 INTRAVENOUS THERAPY 0 64 00 0 Ω 64 00 66.00 06600 PHYSI CAL THERAPY 2, 295 9, 160 11, 455 66.00 06900 ELECTROCARDI OLOGY 69.00 0 0 C 0 0 O 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 C 0 0 71.30 07101 I MPL. DEV. CHARGED TO PATIENT C 0 0 71.30 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 0 03030 ANGI OCARDI OGRAPHY 0 0 76.00 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 2, 339 35, 082 37, 421 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 0 09000 CLINIC 0 0 90.00 236 236 90.00 91.00 09100 EMERGENCY 0 4, 333 0 1, 939 6, 272 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 04050 TELEMEDICINE 0 0 93 00 93 00 Ω 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 95.00 666 666 98.00 09851 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 0 0 09910 CORF 0 99.10 99 10 0 0 Ω SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0 0 109. 00 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 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 0 115, 00 117. 00 06951 OTHER SPECIAL PURPOSE COST CENTERS 0 0 117.00

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159, 361

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205, 205 118. 00

12, 958 194. 00

218, 163 202. 00

0 190. 00

0 191.00

0 193.00

0 200.00

0 201.00

191. 00 19100 RESEARCH

193. 00 19300 NONPALD WORKERS

118.00

200.00

201.00

202.00

SUBTOTALS (SUM OF LINES 1-117)

NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

194.00 07951 OTHER NONREIMBURSABLE COST CENTERS

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

1/28/2016 9:46 am

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141300 Period:

Peri od: Worksheet B From 09/01/2014 Part II To 08/31/2015 Date/Time Prepared:

Cost Center Description **EMPLOYEE** ADMI NI STRATI VE OPERATION OF LAUNDRY & HOUSEKEEPI NG **BENEFITS** LINEN SERVICE & GENERAL **PLANT** DEPARTMENT 5.00 7.00 8. 00 9. 00 4.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT NON HOSP. 1.01 1.01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 0 45, 852 5.00 5.00 7.00 00700 OPERATION OF PLANT 0 0 1, 305 3, 603 7.00 1, 983 00800 LAUNDRY & LINEN SERVICE 8.00 269 152 8 00 9.00 00900 HOUSEKEEPI NG 32 131 1, 356 9.00 867 10.00 01000 DI ETARY 0 1, 172 417 12 58 10.00 01100 CAFETERI A 11.00 0 11.00 C 0 01300 NURSING ADMINISTRATION 13.00 205 Ω 0 0 13.00 0 14.00 01400 CENTRAL SERVICES & SUPPLY 55 85 0 0 14.00 15.00 01500 PHARMACY 1, 300 59 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 ol 16.00 917 16,00 112 02300 PARAMED ED PRGM 23.00 C 0 Ω 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 7, 824 1, 352 1, 003 840 30.00 0 04000 SUBPROVIDER - LPF 40.00 40 00 C 0 41.00 04100 SUBPROVI DER - I RF C 0 0 0 41.00 04200 SUBPROVI DER 0 0 0 42.00 42.00 0 0 04500 NURSING FACILITY 45.00 45.00 0 0 0 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 4, 026 265 124 59 54.00 57.00 05700 CT SCAN 0 0 0 0 57.00 C 58 00 05800 MAGNETIC RESONANCE I MAGING (MRI) O 0 58 00 C 0 05900 CARDIAC CATHETERIZATION 59.00 0 0 0 59.00 60.00 06000 LABORATORY 4, 535 140 0 60 60.00 0 60.01 06001 BLOOD LABORATORY 0000000000 0 60.01 C 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 C 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 42 0 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 C 0 0 64.00 66 00 06600 PHYSI CAL THERAPY 1.920 224 115 66 00 06900 ELECTROCARDI OLOGY 69.00 126 C 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 71.00 C 0 71.30 07101 IMPL. DEV. CHARGED TO PATIENT 0 0 0 71.30 07200 IMPL. DEV. CHARGED TO PATIENT O 72 00 Ω 0 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 C 0 0 0 73.00 03030 ANGI OCARDI OGRAPHY 76.00 76.00 0 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 220 228 88.00 9, 186 3 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 C 90.00 09000 CLI NI C 0 44 23 0 90.00 09100 EMERGENCY 0 91.00 9.450 374 88 91.00 422 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 93.00 04050 TELEMEDICINE 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 0 981 219 65 09851 OTHER REIMBURSABLE COST CENTERS 0 98 00 C 0 0 0 98.00 09910 CORF 0 0 99.10 0 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 109. 00 0 C 0 0 110.00 11000 INTESTINAL ACQUISITION 0 C 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 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.) 0 115.00 0 117. 00 06951 OTHER SPECIAL PURPOSE COST CENTERS 0 117.00 0 SUBTOTALS (SUM OF LINES 1-117) 118, 00 0 45, 416 3, 576 1, 981 1, 333 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 191. 00 19100 RESEARCH 0 0 0 191.00 0 193. 00 19300 NONPALD WORKERS 0 nl193.00 C 0 0 0 194. 00 07951 OTHER NONREI MBURSABLE COST CENTERS 436 27 2 23 194.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 201.00 0 202.00 TOTAL (sum lines 118-201) 45, 852 3,603 1, 983 1, 356 202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141300 Period:

Peri od: Worksheet B From 09/01/2014 Part II To 08/31/2015 Date/Time Prepared:

1/28/2016 9:46 am Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI ON SERVICES & **SUPPLY** 10.00 11.00 13.00 15.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT NON HOSP. 1.01 1.01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 6, 265 10 00 01100 CAFETERI A 4, 439 11.00 4, 439 11.00 01300 NURSING ADMINISTRATION 982 13.00 0 87 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 56 C 1,573 14.00 15.00 01500 PHARMACY 0 0 1, 960 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 0 0 0 171 0 02300 PARAMED ED PRGM 23.00 C 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 826 1, 131 658 0 0 30.00 04000 SUBPROVIDER - LPF 0 40.00 40 00 0 0 41.00 04100 SUBPROVI DER - I RF 0 C 0 0 0 41.00 04200 SUBPROVI DER 0 0 0 42.00 42.00 C 0 04500 NURSING FACILITY 0 0 45.00 45.00 0 0 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 384 0 0 0 54.00 57.00 05700 CT SCAN 0 0 0 0 0 0 0 0 57.00 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) Ω 58 00 0 05900 CARDIAC CATHETERIZATION 0 59.00 C 0 59.00 60.00 06000 LABORATORY 459 0 0 60.00 0 60.01 06001 BLOOD LABORATORY 0000000000 0 0 0 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 C 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. C 0 63.00 0 06400 I NTRAVENOUS THERAPY 0 64.00 0 64.00 66 00 06600 PHYSI CAL THERAPY 278 0 66 00 0 06900 ELECTROCARDI OLOGY 0 0 69.00 C 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 1, 573 0 71.00 71.00 07101 I MPL. DEV. CHARGED TO PATIENT 71.30 0 0 0 0 71.30 72 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 Ω 0 72 00 0 73.00 07300 DRUGS CHARGED TO PATIENTS C 0 1, 960 73.00 03030 ANGI OCARDI OGRAPHY 76.00 76.00 0 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 88.00 500 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 09000 CLI NI C 0 0 0 90.00 09100 EMERGENCY 0 ol 91.00 91.00 814 324 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04050 TELEMEDICINE 93.00 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 0 494 0 0 0 09851 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 C 0 0 98.00 09910 CORF 99.10 0 0 0 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 109. 00 0 C 0 0 110.00 11000 INTESTINAL ACQUISITION 0 C 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 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.) 0 115.00 0 117. 00 06951 OTHER SPECIAL PURPOSE COST CENTERS 0 0 117.00 SUBTOTALS (SUM OF LINES 1-117) 1<u>, 960</u> 118. 00 118, 00 6, 265 4, 381 982 1,573 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 191. 00 19100 RESEARCH 0 0 0 0 191.00 0 193. 00 19300 NONPALD WORKERS 0 193.00 0 C 0 0 194. 00 07951 OTHER NONREI MBURSABLE COST CENTERS 0 58 0 0 0 194. 00 200. 00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 0 201.00 TOTAL (sum lines 118-201) 202.00 6, 265 4, 439 982 1, 573 1, 960 202. 00

Provider CCN: 141300

Peri od:

ALLOCATION OF CAPITAL RELATED COSTS

Part II

From 09/01/2014 08/31/2015 Date/Time Prepared: 1/28/2016 9:46 am Cost Center Description MEDI CAL PARAMED ED Subtotal Intern & Total RECORDS & PRGM Residents Cost LI BRARY & Post Stepdown Adjustments 16.00 23.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FLXT NON HOSP. 1.01 1.01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 2,638 16.00 02300 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 716 39, 959 0 39, 959 30.00 40.00 04000 SUBPROVI DER - I PF 0 40.00 0 0 04100 SUBPROVI DER - I RF 0 41.00 0 0 41.00 0 04200 SUBPROVI DER 0 0 o 42 00 42 00 0 04500 NURSING FACILITY 45.00 0 0 0 0 45.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 371 68, 953 0 68, 953 54.00 0 57.00 05700 CT SCAN 0 57 00 C 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 0 0 0 0 0 0 0 0 59.00 06000 LABORATORY 60.00 436 8.895 8,895 60.00 06001 BLOOD LABORATORY 0 60.01 0 0 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 62.00 0 0 06300 BLOOD STORING, PROCESSING & TRANS. 63 00 42 42 63.00 64.00 06400 I NTRAVENOUS THERAPY 64.00 C 0 06600 PHYSI CAL THERAPY 66.00 50 14.048 14.048 66 00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 126 126 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 1,573 0 1,573 71.00 07101 I MPL. DEV. CHARGED TO PATIENT 71.30 71.30 C 0 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 0 Λ 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 1,960 0 1,960 73.00 03030 ANGI OCARDI OGRAPHY 76.00 76.00 0 OUTPATIENT SERVICE COST CENTERS 47, 883 88.00 08800 RURAL HEALTH CLINIC 325 0 47, 883 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 0 09000 CLINIC 90.00 0 310 310 90.00 91.00 09100 EMERGENCY 671 18, 415 0 18, 415 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 04050 TELEMEDI CI NE 0 93.00 93.00 0 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 2, 489 0 2, 489 95.00 63 09851 OTHER REIMBURSABLE COST CENTERS 0 98.00 0 0 98.00 09910 CORF ol 99. 10 99.10 0 0 0 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 ol 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.) 0 115.00 0 0 0 117. 00 06951 OTHER SPECIAL PURPOSE COST CENTERS 0 0 117 00 0 0 SUBTOTALS (SUM OF LINES 1-117) 118.00 2,632 0 204, 653 204, 653 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 191. 00 19100 RESEARCH 0 0 191 00 0 0 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 13, 510 194. 00 194. 00 07951 OTHER NONREIMBURSABLE COST CENTERS 0 6 13, 510 0 0 200.00 200.00 Cross Foot Adjustments 0 C 201.00 Negative Cost Centers 0 C 0 0 201.00 218, 163 TOTAL (sum lines 118-201) 218, 163 202. 00 202.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS THOMAS H BOYD CRITICAL ACC HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 141300 Peri od: From 09/01/2014 To 08/31/2015 Worksheet B-1 Date/Time Prepared: 1/28/2016 9:46 am CAPITAL RELATED COSTS

		CAP	TAL RELATED CO	OSTS			
	Cost Center Description	NEW BLDG &	BLDG & FIXT	NEW MVBLE	EMPLOYEE	Reconciliation	
	oost denter bescription	FIXT	NON HOSP.	EQUI P	BENEFI TS	Recencification	
		(SQUARE	(SQUARE FEET)	(DOLLAR	DEPARTMENT		
		FEET)		VALUE)	(GROSS SALARI ES)		
		1.00	1. 01	2.00	4. 00	5A	
	GENERAL SERVICE COST CENTERS						
	00100 NEW CAP REL COSTS-BLDG & FIXT	37, 153					1.00
1. 01 2. 00	OO101 CAP REL COSTS-BLDG & FIXT NON HOSP.   OO200 NEW CAP REL COSTS-MVBLE EQUIP	0	7, 074	154, 208			1. 01 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		6, 396, 568	3	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	4, 553	864	37, 402	1, 014, 745		5. 00
7.00	00700 OPERATION OF PLANT	1, 362	0		58, 008	1	7. 00
8. 00 9. 00	O0800   LAUNDRY & LINEN SERVICE   O0900   HOUSEKEEPING	1, 308 273	0	0	29, 429 94, 738	1	8. 00 9. 00
10. 00	01000 DI ETARY	3, 858		o	151, 015	1	10.00
11. 00	01100 CAFETERI A	0	0	0	0		11. 00
	01300 NURSI NG ADMINI STRATI ON	0	0	0	120, 755		13.00
14. 00 15. 00	01400   CENTRAL SERVI CES & SUPPLY   01500   PHARMACY	733 503	0	0	26, 626 0	1	14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	959		283	126, 428	1	16. 00
23. 00	02300 PARAMED ED PRGM	0	0	0	0	1	23. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	14 (00	Ι	10.004	004.040		00.00
30. 00 40. 00	03000   ADULTS & PEDI ATRI CS   04000   SUBPROVI DER - 1 PF	11, 623	0	10, 384 0	984, 268 0	1	30. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	Ö	Ö	ő	0	o o	41. 00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
54. 00	ANCI LLARY SERVI CE COST CENTERS    05400   RADI OLOGY-DI AGNOSTI C	2, 276	0	59, 034	347, 237	' 0	54. 00
57. 00	05700 CT SCAN	2,270		0	0 0	1	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 60. 01	06000   LABORATORY   06001   BLOOD   LABORATORY	1, 205	0	1, 767 0	380, 401 0	1	60. 00 60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		o	0		62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	482	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	1	64.00
66. 00 69. 00	06600  PHYSI CAL THERAPY 06900  ELECTROCARDI OLOGY	1, 922	0	8, 864 0	257, 026 17, 137	1	66. 00 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	17, 137		71.00
71. 30	07101 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71. 30
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03030 ANGI OCARDI OGRAPHY	0	0	0	0	0	73. 00 76. 00
70.00	OUTPATIENT SERVICE COST CENTERS					,,	70.00
88. 00	08800 RURAL HEALTH CLINIC	1, 959	0	33, 948	1, 158, 184	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 91. 00	09000   CLI NI C   09100   EMERGENCY	198 3, 629		0 1, 876	5, 967 1, 215, 643	1	90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,027	Ĭ	1,070	1, 215, 045	,	92. 00
	04050 TELEMEDI CI NE	0	0	0	0	0	93. 00
05.00	OTHER REIMBURSABLE COST CENTERS	T	1 0		250.002		05 00
	09500   AMBULANCE SERVICES   09851   OTHER REIMBURSABLE COST CENTERS	558 0			359, 893 0		95. 00 98. 00
	09910 CORF	O			0	1	99. 10
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION  11000 INTESTINAL ACQUISITION	0	0		0	1	109. 00
	111000   INTESTINAL ACQUISITION   111100   ISLET ACQUISITION	0		0	0	1	110. 00 111. 00
	11300 I NTEREST EXPENSE				Ö		113. 00
	11400 UTILIZATION REVIEW-SNF					1	114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	1	0	l .	115. 00
117.00	06951 OTHER SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	36, 919	0 864	-	6, 347, 982	1	117. 00 118. 00
	NONREI MBURSABLE COST CENTERS	30, 717	1 304	134, 200	0, 347, 702	- 1, 071, 112	1.10.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	0	l .	190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19300  NONPALD WORKERS   07951  OTHER NONRELMBURSABLE COST CENTERS	234	6, 210		48, 586	1	193. 00 194. 00
200.00		254	0,210		40, 300	l .	200. 00
201.00	Negative Cost Centers						201. 00
202. 00		44, 359	14, 443	159, 361	907, 071		202. 00
203. 00	Part I)   Unit cost multiplier (Wkst. B, Part I)	1. 193955	2. 041702	1. 033416	0. 141806		203. 00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				21 1 1 1 300	1	

Health Financial Systems THO	MAS H BOYD CRIT	ICAL ACC HOSPIT	ΓAL	In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 09/01/2014 To 08/31/2015		pared: 6 am
	CAPITAL RELATED COSTS					
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	BLDG & FIXT NON HOSP. (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	1.00	1. 01	2.00	4. 00	5A	
204.00 Cost to be allocated (per Wkst. B, Part II)				0		204. 00
205.00 Unit cost multiplier (Wkst. B, Part				0. 000000		205. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 141300

Peri od: Worksheet B-1 From 09/01/2014

08/31/2015 Date/Time Prepared: 1/28/2016 9:46 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY (HOURS OF & GENERAL PLANT LINEN SERVICE (MFALS (ACCUM. COST) (SQUARE (POUNDS OF SERVICE) SERVED) FEET) LAUNDRY) 5.00 9. 00 10.00 7.00 8.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 1.01 00101 CAP REL COSTS-BLDG & FIXT NON HOSP. 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 7, 605, 441 5.00 00700 OPERATION OF PLANT 7.00 216, 420 30, 965 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 44, 576 1, 308 40, 490 8.00 9.00 00900 HOUSEKEEPI NG 143, 760 273 2,671 84, 320 9.00 01000 DI ETARY 3, 585 251 12, 199 10.00 10.00 194, 469 3.610 01100 CAFETERI A 8, 643 11.00 11.00  $\cap$ 0 01300 NURSING ADMINISTRATION 13.00 148, 489 0 0 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 92, 383 733 0 0 0 14.00 01500 PHARMACY 0 0 15.00 215, 568 503 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 152, 095 959 0 90 0 16.00 02300 PARAMED ED PRGM 0 23.00 23.00 NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 1, 297, 781 11, 623 3, 556 30.00 30.00 20 493 52 175 04000 SUBPROVIDER - IPF 40.00 C 0 40.00 41.00 04100 SUBPROVIDER - IRF 0 0 0 41.00 0 04200 SUBPROVI DER 42.00 0 0 0 42.00 0 04500 NURSING FACILITY O O 45 00 45.00 0 0 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 667, 824 2, 276 2, 530 0 54.00 3,675 57 00 05700 CT SCAN 0 57.00 C 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 0 0 0 58.00 C 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 60.00 06000 LABORATORY 1, 205 0 0 60.00 752, 170 3,720 06001 BLOOD LABORATORY 60 01 0 60 01 0 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 6, 891 0 0 63.00 C 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0 64.00 06600 PHYSI CAL THERAPY 1, 922 375 318 438 66.00 2, 346 0 66.00 69.00 06900 ELECTROCARDI OLOGY 20,878 0 0 69.00 C 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 71.00 71.30 07101 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 71.30 |07200|IMPL. DEV. CHARGED TO PATIENT 0 0 72.00 0 C 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 76.00 03030 ANGI OCARDI OGRAPHY 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 1, 959 88 00 88 00 08800 RURAL HEALTH CLINIC 1, 523, 672 61 13, 665 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER C 0 89.00 90.00 09000 CLI NI C 7, 345 198 90.00 C 09100 EMERGENCY 1, 567, 704 91.00 91.00 3,629 7,640 5, 475 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 93.00 04050 TELEMEDI CI NE 0 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 95.00 95.00 09500 AMBULANCE SERVICES 162, 652 558 4, 462 90 0 09851 OTHER REIMBURSABLE COST CENTERS 0 98.00 98.00 09910 CORF 0 0 0 0 0 99.10 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 111.00 0 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 117. 00 06951 OTHER SPECIAL PURPOSE COST CENTERS 0 0 117.00 SUBTOTALS (SUM OF LINES 1-117) 7, 533, 115 30, 731 40, 454 82, 875 12, 199 118. 00 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 191. 00 19100 RESEARCH 0 O 0 0 191.00 Ω 193. 00 19300 NONPALD WORKERS 0 0 193.00 194. 00 07951 OTHER NONREIMBURSABLE COST CENTERS 72, 326 234 0 194.00 36 1,445 200.00 Cross Foot Adjustments 200. 00 201 00 Negative Cost Centers 201 00 202.00 Cost to be allocated (per Wkst. B, 1, 891, 112 270, 233 67,075 186, 313 282, 503 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0. 248653 8.727047 1.656582 2. 209594 23. 157882 203. 00 6, 265 204. 00 Cost to be allocated (per Wkst. B, 1, 983 204.00 45,852 3,603 1, 356 Part II)

Health Financial Systems THOM	AS H BOYD CRITI	CAL ACC HOSPIT	TAL	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 09/01/2014 To 08/31/2015	Date/Time Pre	narod:
			'	00/31/2013	1/28/2016 9: 4	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE	(HOURS OF	(MEALS	
	(ACCUM. COST)	(SQUARE	(POUNDS OF	SERVICE)	SERVED)	
		FEET)	LAUNDRY)			
	5. 00	7.00	8. 00	9. 00	10.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 006029	0. 116357	0. 048975	0. 016082	0. 513567	205. 00

In Lieu of Form CMS-2552-10 Health Financial Systems COST ALLOCATION - STATISTICAL BASIS Provider CCN: 141300 Peri od: Worksheet B-1 From 09/01/2014 08/31/2015 Date/Time Prepared: 1/28/2016 9:46 am Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL SERVICES & (FTE'S) ADMI NI STRATI ON (COSTED RECORDS & **SUPPLY** REQUIS.) LI BRARY (COSTED (DI RECT (TIME NRSING HRS) REQUIS.) SPENT) 11.00 13.00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FLXT NON HOSP. 1.01 1.01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 7,861 11.00 13.00 01300 NURSING ADMINISTRATION 154 100 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 100 100 14.00 C 01500 PHARMACY 100 15 00 15 00 Ω 0 16.00 01600 MEDICAL RECORDS & LIBRARY 302 C 0 0 106, 375 16.00 02300 PARAMED ED PRGM 23.00 0 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2,004 67 0 0 28, 900 30.00 04000 SUBPROVIDER - IPF 0 0 0 40.00 40.00 04100 SUBPROVI DER - I RF 41.00 0 0 0 0 41.00 0 04200 SUBPROVI DER 0 0 o Ω 42 00 0 42 00 04500 NURSING FACILITY 45.00 0 0 0 0 0 45.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 680 0 0 0 14, 975 54.00 0 0 57.00 05700 CT SCAN 57 00 0 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 0 0 0 59.00 0 59.00 0 06000 LABORATORY 0 60.00 813 0 17, 575 60.00 06001 BLOOD LABORATORY 0 0 60.01 0 0 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 62.00 62.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 0 63 00 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0 64.00 0 06600 PHYSI CAL THERAPY 0 66.00 C 2,000 66.00 0 06900 ELECTROCARDI OLOGY 0 0 69.00 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 100 0 71.00 0 07101 IMPL. DEV. CHARGED TO PATIENT 71.30 71.30 0 C 0 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 72.00 Ω 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 100 0 73.00 03030 ANGI OCARDI OGRAPHY 76.00 76.00 0 OUTPATIENT SERVICE COST CENTERS 13, 100 88.00 08800 RURAL HEALTH CLINIC 886 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 o 89.00 09000 CLI NI C 0 90.00 12 0 0 0 90.00 91.00 09100 EMERGENCY 1,441 33 0 0 27,050 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 04050 TELEMEDI CI NE 0 93.00 93.00 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 875 0 0 0 2,550 95.00 09851 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 0 0 0 98.00 09910 CORF 0 ol 0 0 99.10 99.10 0 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 C 0 ol 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.) 0 115.00 0 0 0 117. 00 06951 OTHER SPECIAL PURPOSE COST CENTERS 0 0 117 00 0 C 0 SUBTOTALS (SUM OF LINES 1-117) 118.00 7, 759 100 100 100 106, 150 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 0 0 191.00 191. 00 19100 RESEARCH 0 0 C 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193.00 194. 00 07951 OTHER NONREIMBURSABLE COST CENTERS 0 102 0 225 194.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 189, 332 206, 171 202. 00 Cost to be allocated (per Wkst. B, 200, 154 124, 297 273, 560 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 1, 893. 320000 1, 242. 970000 2, 735. 600000 1. 938153 203. 00 25. 461646 Cost to be allocated (per Wkst. B, 2, 638 204. 00 204.00 4, 439 982 1, 573 1,960 Part II)

Health Financial Systems TH	OMAS H BOYD CRIT	ICAL ACC HOSPIT	AL	In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 09/01/2014	Worksheet B-1	
				To 08/31/2015		
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	(FTE' S)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
			SUPPLY	REQUIS.)	LI BRARY	
		(DI RECT	(COSTED		(TIME	
		NRSING HRS)	REQUIS.)		SPENT)	
	11.00	13.00	14. 00	15. 00	16.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 564686	9. 820000	15. 73000	19. 600000	0. 024799	205. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 141300 Peri od: Worksheet B-1 From 09/01/2014 To 08/31/2015 Date/Time Prepared: 1/28/2016 9:46 am Cost Center Description PARAMED ED PRGM (ASSI GNED TIME) 23.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 1.01 00101 CAP REL COSTS-BLDG & FIXT NON HOSP. 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 23.00 02300 PARAMED ED PRGM 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 30.00 0 04000 SUBPROVI DER - I PF 0 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 0 41.00 04200 SUBPROVI DER 0 42.00 42.00 04500 NURSING FACILITY 0 45.00 45 00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 00000000000000 57 00 05700 CT SCAN 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 59.00 60.00 06000 LABORATORY 60.00 06001 BLOOD LABORATORY 60 01 60 01 |06200|WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 64.00 06400 I NTRAVENOUS THERAPY 64.00 66.00 06600 PHYSI CAL THERAPY 66.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 71.30 07101 I MPL. DEV. CHARGED TO PATIENT 71.30 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 76.00 03030 ANGI OCARDI OGRAPHY 0 76.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 88 00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 90.00 09000 CLI NI C 0 90.00 09100 EMERGENCY 0 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 93.00 04050 TELEMEDICINE 0 93.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 95 00 09851 OTHER REIMBURSABLE COST CENTERS 0 98.00 98.00 0 99. 10 09910 CORF 99. 10 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 0 111.00 11100 I SLET ACQUISITION 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.) 0 115.00 0 117. 00 06951 OTHER SPECIAL PURPOSE COST CENTERS 117. 00 SUBTOTALS (SUM OF LINES 1-117) 118.00 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 191. 00 19100 RESEARCH 0 191 00 193. 00 19300 NONPALD WORKERS 0 193.00 194. 00 07951 OTHER NONREIMBURSABLE COST CENTERS 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, 0 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 203. 00 Cost to be allocated (per Wkst. B, 204. 00 204.00 Part II)

Health Financial Systems THOW	MAS H BOYD CRITIC	CAL ACC HOSPITAL	In Lie	u of Form CMS-2552	2-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 141300	Peri od:	Worksheet B-1	
			From 09/01/2014 To 08/31/2015	Date/Time Prepare 1/28/2016 9:46 am	
Cost Center Description	PARAMED ED		•		
	PRGM				
	(ASSI GNED				
	TIME)				
	23. 00				
205.00 Unit cost multiplier (Wkst. B, Part	0.000000			205	. 00

Provider CCN: 141300

Peri od:

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

In Lieu of Form CMS-2552-10
Worksheet C

From 09/01/2014 Part I 08/31/2015 Date/Time Prepared: 1/28/2016 9:46 am Title XVIII Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs Di sal I owance from Wkst. B, Adj Part I, col. 26) 4. 00 5. 00 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 30 00 2, 187, 386 2, 187, 386 Ω 04000 SUBPROVI DER - I PF 40.00 0 0 40.00 04100 SUBPROVI DER - I RF 0 0 0 41.00 0 41.00 04200 SUBPROVI DER 0 0 0 42.00 42.00 0 0 04500 NURSING FACILITY 45.00 0 0 45.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 912, 392 912, 392 0 54.00 0 0 0 0 0 57 00 05700 CT SCAN 0 57.00 0  $\cap$ 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 59.00 60.00 06000 LABORATORY 1, 012, 698 1, 012, 698 60.00 0 06001 BLOOD LABORATORY 60.01 0 C 0 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 63.00 8,604 8,604 0 63.00 06400 INTRAVENOUS THERAPY 64 00 0 64 00 C 66.00 06600 PHYSI CAL THERAPY 435, 510 435, 510 0 66.00 69.00 06900 ELECTROCARDI OLOGY 26,069 26, 069 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 124, 297 124, 297 0 71.00 07101 I MPL. DEV. CHARGED TO PATIENT 71 30 71 30 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 273, 560 273, 560 0 73.00 76 00 03030 ANGI OCARDI OGRAPHY 0 0 76 00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 1, 997, 878 1, 997, 878 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 89.00 o 90 00 09000 CLINIC 11, 205 11, 205 0 90 00 0 91.00 09100 EMERGENCY 2, 165, 538 2, 165, 538 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 331, 339 331, 339 0 92.00 92.00 93.00 04050 TELEMEDI CI NE 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 242, 778 242, 778 0 0 95.00 09851 OTHER REIMBURSABLE COST CENTERS 98.00 98.00 0 99.10 09910 CORF 0 0 0 99. 10 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0 0 109. 00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 | SLET ACQUISITION 0 111.00 0 0 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 117. 00 06951 OTHER SPECIAL PURPOSE COST CENTERS 0 117.00 200.00 Subtotal (see instructions) 9, 729, 254 9, 729, 254 0 200. 00 201.00 Less Observation Beds 331, 339 331, 339 0 201.00 202.00 Total (see instructions) 9, 397, 915 9, 397, 915 0 202. 00

Health Financial Systems THOMAS H BOYD CRITICAL ACC HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 141300 Peri od: Worksheet C From 09/01/2014 Part I Date/Time Prepared: 08/31/2015 1/28/2016 9:46 am Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 757, 852 757, 852 30.00 30.00 40.00 04000 SUBPROVIDER - IPF 0 40.00 04100 SUBPROVIDER - IRF 0 0 41.00 41.00 42.00 04200 SUBPROVI DER 0 0 42.00 04500 NURSING FACILITY 0 45.00 0 45.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 59, 263 3, 366, 596 3, 425, 859 0.266325 0.000000 54.00 57.00 05700 CT SCAN 0.000000 0.000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 0.000000 0.000000 58 00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 60.00 06000 LABORATORY 163, 223 3, 144, 902 3, 308, 125 0.306124 0.000000 60.00 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 60.01 C 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 Λ 0.000000 0.000000 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 273803 0.000000 63.00 10,894 20,530 31, 424 63.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 0.000000 64.00 06600 PHYSI CAL THERAPY 864.045 1, 007, 812 0.000000 66.00 143, 767 0.432134 66,00 69.00 06900 ELECTROCARDI OLOGY 2,820 337, 613 340, 433 0.076576 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 285774 0.000000 71.00 218, 935 216, 013 434, 948 71.00 07101 I MPL. DEV. CHARGED TO PATIENT 0.000000 0.000000 71.30 71.30 07200 IMPL. DEV. CHARGED TO PATIENT 72.00  $\cap$ 0.000000 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 244, 881 244, 316 489, 197 0.559202 0.000000 73.00

95.00 09500 AMBULANCE SERVICES 0 1, 277, 206 1, 277, 206 0.190085 0.000000 95.00 98.00 09851 OTHER REIMBURSABLE COST CENTERS 0 0.000000 0.000000 98.00 C 99.10 09910 CORF 0 0 99. 10 SPECIAL PURPOSE COST CENTERS ō 109.00 109.00 10900 PANCREAS ACQUISITION 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 l110. 00 111.00 11100 | SLET ACQUISITION 0 C 0 111.00 113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)

113.00 114.00 115.00 117. 00 06951 OTHER SPECIAL PURPOSE COST CENTERS 117. 00 15, 125, 077 200.00 Subtotal (see instructions) 1,603,360 13, 521, 717 200. 00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 1,603,360 13, 521, 717 15, 125, 077 202.00

1/28/2016 9:46 am Title XVIII Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 40. 00 | 04000 | SUBPROVI DER - I PF 40.00 41. 00 04100 SUBPROVI DER - I RF 41.00 42.00 04200 SUBPROVI DER 42.00 04500 NURSING FACILITY 45.00 45.00 ANCILLARY SERVICE COST CENTERS 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 57. 00 | 05700 CT SCAN 0.000000 57.00 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59 00 60. 00 06000 LABORATORY 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 66. 00 06600 PHYSI CAL THERAPY 0.000000 66.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 71 00 71. 30 07101 IMPL. DEV. CHARGED TO PATIENT 0.000000 71.30 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.000000 73.00 03030 ANGI OCARDI OGRAPHY 76.00 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 89.00 90.00 09000 CLI NI C 0.000000 90.00 91.00 09100 EMERGENCY 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 92.00 04050 TELEMEDICINE 0.000000 93.00 93.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0.000000 95.00 95.00 09851 OTHER REIMBURSABLE COST CENTERS 98 00 0.000000 98.00 09910 CORF 99.10 99. 10 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 111.00 11100 I SLET ACQUISITION 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. 00 117.00 06951 OTHER SPECIAL PURPOSE COST CENTERS 117. 00 200.00 Subtotal (see instructions) 200.00 201 00 201.00 Less Observation Beds

202. 00

202.00

Total (see instructions)

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES In Lieu of Form CMS-2552-10 | Peri od: | Worksheet C | From 09/01/2014 | Part I | To 08/31/2015 | Date/Time Prepared: Provider CCN: 141300

					10 08/31/2015	1/28/2016 9:4	
			Ti t	le XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	oost conten bosci i pti on	(from Wkst. B,	Adj.	l lotal oosts	Di sal I owance	10141 00313	
		Part I, col.	, ,		Di oui i oliunoo		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
30.00	03000 ADULTS & PEDIATRICS	2, 187, 386		2, 187, 38	6 0	2, 187, 386	30.00
40. 00	04000 SUBPROVI DER - I PF	2, 107, 000		1	o o	_,,	40.00
41. 00	04100 SUBPROVI DER - I RF	0			0 0	Ö	41.00
42. 00	04200 SUBPROVI DER	0			o o	0	42. 00
45. 00	04500 NURSING FACILITY	0		1	0 0	0	45. 00
45.00	ANCI LLARY SERVI CE COST CENTERS				0 0	0	45.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	912, 392		912, 39	2 0	912, 392	54.00
57. 00	05700 CT SCAN	712, 372			0 0	912, 392	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
59. 00		0			0 0	0	59.00
60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1 012 400		1 012 40	-	-	
		1, 012, 698		1, 012, 69		1,012,070	1
60. 01	06001 BLOOD LABORATORY	0			٥	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	8, 604		8, 60		8, 604	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	_		0	0	64. 00
66. 00	06600 PHYSI CAL THERAPY	435, 510	l	, .		435, 510	
69. 00	06900 ELECTROCARDI OLOGY	26, 069		26, 06		26, 069	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	124, 297		124, 29		124, 297	71. 00
71. 30	07101 I MPL. DEV. CHARGED TO PATIENT	0			0	0	71. 30
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0			0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	273, 560		273, 56		,	1
76. 00	03030 ANGI OCARDI OGRAPHY	0			0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	1, 997, 878		1, 997, 87	0	1, 997, 878	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89. 00
90.00	09000  CLI NI C	11, 205		11, 20	5 0	11, 205	90. 00
91. 00	09100 EMERGENCY	2, 165, 538		2, 165, 53	0	2, 165, 538	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	331, 339		331, 33	9	331, 339	92.00
93.00	04050 TELEMEDI CI NE	0			0 0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	242, 778		242, 77	8 0	242, 778	95. 00
98. 00	09851 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	98. 00
99. 10	09910 CORF	0			o	0	99. 10
	SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0			0	0	109. 00
110.00	11000 INTESTINAL ACQUISITION	0			o	0	110. 00
111.00	11100 ISLET ACQUISITION	0			o	0	111. 00
113.00	11300 INTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0			0	0	115. 00
117. 00	06951 OTHER SPECIAL PURPOSE COST CENTERS	0			0	0	117. 00
200.00	Subtotal (see instructions)	9, 729, 254	0	9, 729, 25	4 0	9, 729, 254	200.00
201.00		331, 339	l .	331, 33		331, 339	
202.00		9, 397, 915	l .				
		•	•	•	•	•	•

201.00

202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 141300 Peri od: Worksheet C From 09/01/2014 Part I Date/Time Prepared: 08/31/2015 1/28/2016 9:46 am Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 757, 852 757, 852 30.00 30.00 40.00 04000 SUBPROVIDER - IPF 0 40.00 04100 SUBPROVIDER - IRF 0 0 41.00 41.00 42.00 04200 SUBPROVI DER 0 0 42.00 04500 NURSING FACILITY 0 45.00 0 45.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 59, 263 3, 366, 596 3, 425, 859 0.266325 0.000000 54.00 57.00 05700 CT SCAN 0.000000 0.000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 0.000000 0.000000 58 00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 60.00 06000 LABORATORY 163, 223 3, 144, 902 3, 308, 125 0.306124 0.000000 60.00 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 60.01 C 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 Λ 0.000000 0.000000 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 273803 0.000000 63.00 10,894 20,530 31, 424 63.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 0.000000 64.00 06600 PHYSI CAL THERAPY 864.045 1, 007, 812 0.000000 66.00 143, 767 0.432134 66,00 69.00 06900 ELECTROCARDI OLOGY 2,820 337, 613 340, 433 0.076576 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 285774 0.000000 71.00 218, 935 216, 013 434, 948 71.00 07101 I MPL. DEV. CHARGED TO PATIENT 0.000000 0.000000 71.30 71.30 07200 IMPL. DEV. CHARGED TO PATIENT 72.00  $\cap$ 0.000000 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 244, 881 244, 316 489, 197 0.559202 0.000000 73.00 03030 ANGI OCARDI OGRAPHY 76.00 0.000000 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 2, 062, 159 2, 062, 159 0.968828 0.000000 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0.000000 89.00 89.00 90.00 09000 CLI NI C 0 13, 491 13, 491 0.830554 0.000000 90.00 09100 EMERGENCY 1.384095 91.00 91.00 1, 725 1, 562, 863 1, 564, 588 0.000000 411, 983 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 411, 983 0.804254 0.000000 92.00 04050 TELEMEDICINE 93.00 0 0.000000 0.000000 93.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 1, 277, 206 1, 277, 206 0.190085 0.000000 95.00 98.00 09851 OTHER REIMBURSABLE COST CENTERS 0 0.000000 0.000000 98.00 C 99.10 09910 CORF 0 0 99. 10 SPECIAL PURPOSE COST CENTERS ō 109.00 109.00 10900 PANCREAS ACQUISITION 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 l110. 00 111.00 11100 | SLET ACQUISITION 0 C 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.) 115.00 117. 00 06951 OTHER SPECIAL PURPOSE COST CENTERS 117. 00 200.00 Subtotal (see instructions) 1,603,360 13, 521, 717 15, 125, 077 200. 00

1,603,360

13, 521, 717

15, 125, 077

201.00

202.00

Less Observation Beds

Total (see instructions)

				1/28/2016 9:46 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30. 00
40. 00   04000   SUBPROVI DER - 1 PF				40. 00
41. 00   04100   SUBPROVI DER - 1 RF				41. 00
42. 00   04200   SUBPROVI DER				42.00
45.00 04500 NURSING FACILITY				45. 00
ANCILLARY SERVICE COST CENTERS				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
57. 00  05700 CT SCAN	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00   06000   LABORATORY	0. 000000			60.00
60. 01   06001   BLOOD   LABORATORY	0. 000000			60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64. 00
66. 00   06600 PHYSI CAL THERAPY	0. 000000			66.00
69. 00   06900   ELECTROCARDI OLOGY	0. 000000			69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
71. 30 07101 IMPL. DEV. CHARGED TO PATIENT	0. 000000			71. 30
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000			71. 30
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00   03030  ANGI OCARDI OGRAPHY	0. 000000			76.00
OUTPATIENT SERVICE COST CENTERS	0.000000			70.00
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89. 00
90. 00   09000   CLI NI C	0. 000000			90.00
91. 00   09100   EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
93. 00   04050   TELEMEDI CI NE	0. 000000			93. 00
OTHER REIMBURSABLE COST CENTERS	0.000000			73.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
98. 00 09851 OTHER REIMBURSABLE COST CENTERS	0. 000000			98.00
99. 10   09910   CORF	0.00000			99. 10
SPECIAL PURPOSE COST CENTERS				77. 10
109. 00 10900 PANCREAS ACQUISITION				109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON				110.00
111. 00 11100   SLET ACQUISITION				111.00
113. 00 11300   NTEREST 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
117. 00 06951 OTHER SPECIAL PURPOSE COST CENTERS				117. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	1			1=32.00

Health Financial Systems THOW	IAS H BOYD CRIT	I CAL ACC HOSE	PI TAL	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi de	er CCN: 141300	Period: From 09/01/2014 To 08/31/2015	Worksheet D Part II	pared:
		Ti	tle XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charge	es Ratio of Co	st Inpatient	Capital Costs	
	Related Cost	(from Wkst.	C, to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col	. (col . 1 ÷ co	ol. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	68, 953	3, 425, 8	59 0. 0201	27 43, 293	871	54.00
57. 00  05700 CT SCAN	0		0.0000	000	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0.0000	000	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0.0000	000	0	59. 00
60. 00 06000 LABORATORY	8, 895	3, 308, 1	25 0.0026	80, 626	217	60.00
60. 01 06001 BLOOD LABORATORY	0		0.0000		0	60, 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0.0000	000	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	42	31, 4			10	63.00
64.00 06400 I NTRAVENOUS THERAPY	0		0.0000		0	1
66. 00   06600 PHYSI CAL THERAPY	14, 048	1, 007, 8			132	
69. 00 06900 ELECTROCARDI OLOGY	126					1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 573					71. 00
71.30 07101 IMPL. DEV. CHARGED TO PATIENT	0	1	0.0000		0	71. 30
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0		0.0000		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 960	489, 1			408	
76. 00 03030 ANGI OCARDI OGRAPHY	0	, .	0.0000		0	
OUTPATIENT SERVICE COST CENTERS	_				_	
88. 00 08800 RURAL HEALTH CLINIC	47, 883	2, 062, 1	59 0. 0232	220 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0 0.0000		Ö	
90. 00   09000   CLI NI C	310				0	
91. 00   09100   EMERGENCY	18, 415				0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 695				0	
93. 00   04050   TELEMEDI CI NE	11,070		0 0.0000		0	
OTHER REIMBURSABLE COST CENTERS	·	1	5, 0000	.55,	ı	70.00
95. 00 09500 AMBULANCE SERVICES						95. 00
98. 00 09851 OTHER REIMBURSABLE COST CENTERS	0		0.0000	000	0	1
200.00 Total (lines 50-199)	173, 900	13, 090, 0		338, 923		200.00

| Peri od: | Worksheet D | From 09/01/2014 | Part IV | To 08/31/2015 | Date/Time Prepared: 
 Heal th Financial
 Systems
 THOMAS H BOYD CRITIC

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provi der CCN: 141300 THROUGH COSTS

					10 00/31/2013	1/28/2016 9: 4	
				e XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
		Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	
57.00	05700  CT SCAN	0	0		0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59. 00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
71. 30	07101 I MPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	71. 30
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
76.00	03030 ANGI OCARDI OGRAPHY	0	0		0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS				·		1
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89. 00
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
93.00	04050 TELEMEDI CI NE	0	0		0 0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS		<u> </u>		<u>'</u>	<u> </u>	1
95.00	09500 AMBULANCE SERVICES						95. 00
98.00	09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98. 00
200.00	Total (lines 50-199)	0	0		0 0	0	200. 00
		•	•	•	•	•	-

Health Financial Systems		THOMAS H BOYD CRITICAL	ACC HOSPITAL	In Lieu of Form CMS-2552-10		
	APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCLLLARY SERVICE OTHER PASS	Provider CCN: 141300	Peri od:	Worksheet D	

Period: From 09/01/2014 To 08/31/2015 Part IV THROUGH COSTS Date/Time Prepared: 1/28/2016 9:46 am Title XVIII Hospi tal Cost Total Charges Ratio of Cost I npati ent Cost Center Description Total Outpati ent Outpati ent (from Wkst. C, to Charges Ratio of Cost Program Cost (sum of Part I, col. (col. 5 ÷ col to Charges Charges col. 2, 3 and 8) 7)  $(col. 6 \div col$ 4) 7) 6.00 7.00 8.00 9.00 10.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 00 3, 425, 859 0.000000 0.000000 43, 293 54.00 57. 00 | 05700 CT SCAN 0.000000 0.000000 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0.000000 58.00 000000000000 0 58.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 59.00 0 0.000000 60.00 06000 LABORATORY 3, 308, 125 0.000000 80, 626 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 0 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0.000000 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 31, 424 0.000000 0.000000 63 00 7,517 63 00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 0.000000 Ω 64.00 66.00 06600 PHYSI CAL THERAPY 1,007,812 0.000000 0.000000 9, 450 06900 ELECTROCARDI OLOGY 0.000000 0.000000 69.00 340, 433 2, 256 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 434, 948 0.000000 0.000000 93, 898 71 00 71 00 71. 30 07101 IMPL. DEV. CHARGED TO PATIENT C 0.000000 0.000000 0 71.30 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 0.000000 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 489, 197 101, 883 73 00 0.000000 0.000000 73 00 03030 ANGI OCARDI OGRAPHY 76.00 0.000000 0.000000 0 76.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 2, 062, 159 88.00 0 0.000000 0.000000 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0.000000 89 00 89 00 Ω 90.00 09000 CLI NI C 13, 491 0.000000 0.000000 0 90.00 91.00 09100 EMERGENCY 1, 564, 588 0.000000 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 411, 983 0.000000 0.000000 0 92.00 04050 TELEMEDICINE 0 0.000000 0.000000 93.00 93.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 0 98. 00 09851 OTHER REIMBURSABLE COST CENTERS 0.000000 0.000000 0 98.00 13, 090, 019 338, 923 200. 00 200.00 Total (lines 50-199)

THROUGH COSTS

						1/28/2016 9:4	16 am
			Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through	n		
		Costs (col. 8		Costs (col.	9		
		x col. 10)		x col. 12)			
		11.00	12.00	13.00			
ANG	CILLARY SERVICE COST CENTERS						
54.00 054	400 RADI OLOGY-DI AGNOSTI C	0	C		0		54.00
57. 00 05	700 CT SCAN	0	C	)	0		57. 00
58. 00 058	800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	)	0		58. 00
59. 00 059	900 CARDIAC CATHETERIZATION	0	C	)	0		59. 00
60.00 060	000 LABORATORY	0	C	)	0		60.00
60. 01 060	001 BLOOD LABORATORY	0	C	)	0		60. 01
62. 00 062	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	C	1	0		62.00
63. 00 063	300 BLOOD STORING, PROCESSING & TRANS.	o	C	1	0		63.00
64.00 064	400 INTRAVENOUS THERAPY	o	C	1	0		64.00
66.00 066	600 PHYSI CAL THERAPY	o	C	1	0		66. 00
69. 00 069	900 ELECTROCARDI OLOGY	o	C	1	0		69. 00
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	C	1	0		71. 00
71. 30 07	101 IMPL. DEV. CHARGED TO PATIENT	o	C	1	0		71. 30
72. 00 072	200 IMPL. DEV. CHARGED TO PATIENT	0	C	)	0		72. 00
73. 00 073	300 DRUGS CHARGED TO PATIENTS	0	C	)	0		73. 00
76. 00 030	O30 ANGI OCARDI OGRAPHY	0	C	)	0		76. 00
OUT	TPATIENT SERVICE COST CENTERS				<u> </u>		
88. 00 088	800 RURAL HEALTH CLINIC	0	C		0		88. 00
89. 00 089	900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	)	0		89. 00
90.00 090	DOO CLI NI C	0	C	)	0		90.00
91.00 09	100 EMERGENCY	o	C	1	0		91.00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)	o	C	1	0		92.00
93.00 040	050 TELEMEDICINE	o	C	1	0		93.00
OTH	HER REIMBURSABLE COST CENTERS	<u> </u>					
95. 00 09!	500 AMBULANCE SERVICES						95. 00
	851 OTHER REIMBURSABLE COST CENTERS	0	C	)	0		98. 00
200. 00	Total (lines 50-199)	0	C	)	0		200. 00
•					*		-

Health Financial Systems THOW	MAS H BOYD CRIT	ICAL ACC HOSPIT	ΓAL	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST			Period: From 09/01/2014 To 08/31/2015	Worksheet D Part V Date/Time Pre 1/28/2016 9:4	pared: 6 am
		Ti tl	e XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 266325		1, 297, 33	7 0	0	
57. 00  05700   CT   SCAN	0. 000000			0	0	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			0	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60. 00   06000   LABORATORY	0. 306124	0	1, 458, 19	0	0	60.00
60. 01   06001   BL00D   LABORATORY	0. 000000	0		0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 273803	0	10, 05	6 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0	0	64.00
66. 00   06600 PHYSI CAL THERAPY	0. 432134	0	254, 61	1 0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 076576	0	123, 01	6 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 285774	0	108, 81	6 0	0	71. 00
71.30 07101 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0	0	71. 30
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 559202	0	147, 12	8 280	0	73. 00
76. 00 03030 ANGI OCARDI OGRAPHY	0. 000000	0		0	0	76. 00
OUTPATIENT SERVICE COST CENTERS				*		1
88. 00 08800 RURAL HEALTH CLINIC	0.000000				0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90. 00   09000   CLI NI C	0. 830554	0	10, 46	4 0	0	90.00
91. 00 09100 EMERGENCY	1. 384095	0	541, 33	1 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 804254	0	163, 36	6 0	0	92.00
93. 00  04050   TELEMEDI CI NE	0. 000000	0		0	0	93. 00
OTHER REIMBURSABLE COST CENTERS		•	•			1
95. 00 09500 AMBULANCE SERVI CES	0. 190085			0		95. 00
98. 00 09851 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	98. 00
200.00 Subtotal (see instructions)		0	4, 114, 31	5 280	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)		0	4, 114, 31	280	0	202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems THOMAS H BOYD CRITICAL ACC HOSPITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 141300 Peri od: Worksheet D From 09/01/2014 Part V 08/31/2015 Date/Time Prepared: 1/28/2016 9:46 am Titl<u>e XVIII</u> Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 345, 513 0 54.00 57.00 05700 CT SCAN 0 57.00 0 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0 05900 CARDIAC CATHETERIZATION 59.00 0 59.00 60. 00 | 06000 | LABORATORY 446, 387 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 2,753 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 64.00 06600 PHYSI CAL THERAPY 110.026 0 66 00 66 00 69.00 06900 ELECTROCARDI OLOGY 9, 420 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 31, 097 0 71.00 07101 | MPL. DEV. CHARGED TO PATIENT 71.30 0 71.30 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 82, 274 157 73.00 03030 ANGI OCARDI OGRAPHY 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 90.00 09000 CLI NI C 8, 691 0 90.00 09100 EMERGENCY 749, 254 91.00 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 131, 388 92.00 92.00 0 93.00 04050 TELEMEDICINE 0 93.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 0 09851 OTHER REIMBURSABLE COST CENTERS 98.00 0 0 98.00 200.00 Subtotal (see instructions) 1, 916, 803 157 200.00 201.00 Less PBP Clinic Lab. Services-Program 201. 00

1, 916, 803

157

202.00

Only Charges

Net Charges (line 200 +/- line 201)

202.00

Health Financial Systems THOMAS H BOYD CRITICAL ACC HOSPITAL In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 141300 Period: From 09/01/2014 Form 09/01/2014 To 08/31/2015 Part V Date/Time Prepared:

			Component	t CCN: 14Z300   T	o 08/31/2015	Date/Time Pre 1/28/2016 9:4	pared:
			Ti tl	e XVIII S	wing Beds - SNF		<u>o ani</u>
				Charges	in ng bodo on	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C.	inst.)	Servi ces	Services Not	( , , , , , , , , , , , , , , , , , , ,	
		Part I, col. 9		Subject To	Subject To		
		·		Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 266325	0	C	0	0	54. 00
57. 00	05700 CT SCAN	0. 000000	0	C	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	C	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	C	0	0	59. 00
60.00	06000 LABORATORY	0. 306124	0	l c	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	l c	0	0	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	l c	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 273803	0	l c	0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64. 00
66. 00	06600 PHYSI CAL THERAPY	0. 432134	0	l c	0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 076576	0	l c	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 285774	0	l c	0	0	71.00
71. 30	07101 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0	l c	0	0	71. 30
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0	l c	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 559202	0	l c	0	0	73.00
76. 00	03030 ANGI OCARDI OGRAPHY	0. 000000	0	l c	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90.00	09000 CLI NI C	0. 830554	0	c	0	0	90.00
91. 00	09100 EMERGENCY	1. 384095	0	l c	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 804254	0	l c	0	0	92.00
93. 00	04050 TELEMEDI CI NE	0. 000000	0	l c	0	0	93. 00
ľ	OTHER REIMBURSABLE COST CENTERS			•			1
95. 00	09500 AMBULANCE SERVICES	0. 190085		C			95. 00
98. 00	09851 OTHER REIMBURSABLE COST CENTERS	0. 000000	0	l c	0	0	98. 00
200.00	Subtotal (see instructions)		0	C	0	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0		201. 00
	Only Charges						
202.00			0	l c	0	0	202. 00
'	,	•	•	•		•	•

Health Financial Systems THOMAS H BOYD CRITICAL ACC HOSPITAL In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 141300 From 09/01/2014 Part V

Component CCN: 14Z300 To 08/31/2015 Date/Time Prepared:

		Componer	nt CCN: 14Z300	То	08/31/2	Date/Time Pre 1/28/2016 9:4	
		Ti t	le XVIII	Swi ng	g Beds -	Cost	
	Cos	sts					
Cost Center Description	Cost	Cost					
	Rei mbursed	Reimbursed					
	Servi ces	Services Not					
	Subject To	Subject To					
	Ded. & Coins.	Ded. & Coins.					
	(see inst.)	(see inst.)	_				
	6. 00	7. 00					
ANCI LLARY SERVI CE COST CENTERS		T	al				
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0		0				54.00
57. 00 05700 CT SCAN	0		0				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0				59.00
60. 00   06000   LABORATORY	0		0				60.00
60. 01   06001   BLOOD LABORATORY	0		0				60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0				62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0				63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0		0				64.00
66. 00 06600 PHYSI CAL THERAPY	0		0				66. 00
69. 00 06900 ELECTROCARDI OLOGY	0		0				69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0		0				71.00
71. 30 O7101 IMPL. DEV. CHARGED TO PATIENT	0						71. 30
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0						72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		0				73.00
76. 00 03030 ANGI OCARDI OGRAPHY  OUTPATI ENT SERVI CE COST CENTERS	0		0				76. 00
88. 00   08800   RURAL HEALTH CLINIC		1	ol				88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	-	0				89.00
90. 00   09000   CLINIC	0						90.00
91. 00   09100   EMERGENCY	0						91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	0		ol				92.00
93.00 04050 TELEMEDICINE	0		0				93. 00
OTHER REIMBURSABLE COST CENTERS			<u> </u>				33.00
95. 00 09500 AMBULANCE SERVI CES							95. 00
98. 00 09851 OTHER REIMBURSABLE COST CENTERS			o				98. 00
200.00 Subtotal (see instructions)			õ				200. 00
201.00 Less PBP Clinic Lab. Services-Program							201. 00
Only Charges							
202.00 Net Charges (line 200 +/- line 201)	0		o				202. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	'	1	1				

Health Financial Systems	THOMAS H BOYD CRITICAL	ACC HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141300	Peri od: From 09/01/2014	Worksheet D-1
				Date/Time Prepared:
				1/28/2016 9:46 am
		Title XVIII	Hospi tal	Cost

		Title XVIII	Hospi tal	1/28/2016 9: 4 Cost	6 am
	Cost Center Description	THE AVIT	1103pi tui	0031	
	DADT A ALL DOOM DED COMPONENTO			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		1, 218	1. 00
2.00	Inpatient days (including private room days, excluding swing-be	d and newborn days)		615	2. 00
3.00	Private room days (excluding swing-bed and observation bed days	). If you have only pri	vate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	days)		435	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	188	5. 00
	reporting period	3 7			
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December 3	31 of the cost	383	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	14	7. 00
7.00	reporting period	adys) through becomber	01 01 110 0031		7.00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3°	1 of the cost	18	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Dreamer (evaluding	swing had and	294	9. 00
9.00	newborn days)	the Program (excruding	Swifig-bed and	294	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private ro	oom days)	188	10. 00
44.00	through December 31 of the cost reporting period (see instructi			202	44 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent		oom days) after	383	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea			0	13. 00
14. 00	Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(		0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services	through Docombon 21 or	F the cost		17. 00
17.00	reporting period	through becember 31 of	the cost		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18. 00
40.00	reporting period			400.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	132. 03	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	132. 03	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	21 of the cost reporti	ng poriod (line	2, 187, 386 0	21. 00 22. 00
22.00	5 x line 17)	31 of the cost report	ng perrou (Trie	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	g period (line 6	0	23. 00
04.00	x line 18)	04 6 11		4 040	04.00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	31 of the cost reportin	ng period (iine	1, 848	24. 00
25.00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	2, 377	25. 00
	x line 20)				
26. 00 27. 00	Total swing-bed cost (see instructions)	ino 21 minus lino 24)		1, 055, 310 1, 132, 076	
27.00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	THE 21 IIITHUS TITLE 20)		1, 132, 076	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 minu		tions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost an	a private room cost di	rrerential (line	1, 132, 076	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 840. 78	38. 00
39. 00	Program general inpatient routine service cost per drem (see 1			541, 189	39.00
40. 00	Medically necessary private room cost applicable to the Program	•		0	40.00
41. 00				541, 189	
	, J. J		'	2,,	

Heal th	Financial Systems THOM	AS H BOYD CRIT	I CAL ACC HOSPI	TAL	In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 141300	Peri od: From 09/01/2014	Worksheet D-1	
					To 08/31/2015		
			Ti ti	e XVIII	Hospi tal	1/28/2016 9: 4 Cost	6 am
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	
		1. 00	2.00	3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)			0.00		2.22	42. 00
42.00	Intensive Care Type Inpatient Hospital Units		1	1			1 42 00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wks					126, 334	48. 00
49. 00	Total Program inpatient costs (sum of lines 4	11 through 48)	(see instructi	ons)		667, 523	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D. sur	n of Parts L and	0	50.00
	111)		`	•			
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	ry services (f	rom Wkst. D, s	sum of Parts II	0	51. 00
52.00	Total Program excludable cost (sum of lines 5					0	52. 00
53. 00	Total Program inpatient operating cost exclud		elated, non-phy	ysician anesth	netist, and	0	53. 00
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	02)					
54.00	Program di scharges					0	54. 00
55. 00	Target amount per discharge					0.00	•
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and ta	arget amount (	line 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ng cost and te	arget amount (	THE SE III HGS	11110 00)	ő	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996,	updated and co	ompounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost report um	odated by the i	market basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines				the amount by	0	61.00
	which operating costs (line 53) are less than		ts (lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)			ő	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only)	ts through Dece	ember 31 of the	e cost reporti	ng period (See	346, 067	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	per 31 of the o	cost reportino	g period (See	705, 019	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swips had SNE inpatient routing	no costs (lino	44 plus line	4E) (+; +  o V/	Lonly) For	1 051 004	44 00
00.00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ie costs (Title	64 prus rine (	bb)(title xvii	i diliy). Fdi	1, 051, 086	00.00
67. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	n December 31 (	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	o costs after [	December 31 of	the cost ren	orting period	0	68. 00
00.00	(line 13 x line 20)		occember 31 or	the cost repo	or tring period	Ĭ	00.00
69. 00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facili				)		70.00
71. 00	Adjusted general inpatient routine service co	ost per diem (I					71. 00
72.00	Program routine service cost (line 9 x line 7	•	m (line 14 v li	ino 3E)			72.00
73. 00 74. 00	Medically necessary private room cost applica Total Program general inpatient routine servi						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient r	•			Part II, column		75. 00
7, 00	26, line 45)	0)					7, 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
	Inpatient routine service cost (line 74 minus	,					78.00

Health Financial Systems	THOM	AS H BOYD CRITI	ICAL ACC HOSPIT	TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT	OPERATING COST		Provi der		Peri od:	Worksheet D-1	
					From 09/01/2014 To 08/31/2015	Date/Time Prep 1/28/2016 9:40	
			Ti tl	e XVIII	Hospi tal	Cost	
Cost Center	Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
			(from line 27)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OB	SERVATION BED PASS THROUGH (	COST					
90.00 Capital-related c	cost	39, 959	1, 132, 076	0. 03529	7 331, 339	11, 695	90.00
91.00 Nursing School co	st	0	1, 132, 076	0. 000000	331, 339	0	91.00
92.00 Allied health cos	t	0	1, 132, 076	0. 000000	331, 339	0	92.00
93.00 All other Medical	Educati on	0	1, 132, 076	0. 000000	331, 339	0	93. 00

Health Financial Systems	THOMAS H BOYD CRITICAL A	ACC HOSPITAL		In Lie	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:	141300	Peri od:	Worksheet D-3

Health Financial Systems THOMAS H BOYD CRITICA	L ACC HOSPI	IAL	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 141300	Peri od:	Worksheet D-3	
			From 09/01/2014		
			To 08/31/2015		
	T: +1	e XVIII	Hospi tal	1/28/2016 9: 4 Cost	<u>6 am</u>
Cost Center Description		Ratio of Cos		Inpatient	
Cost Center Description					
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1	306, 865		30.00
40. 00   04000  SUBPROVI DER - I PF			300, 000		40.00
41. 00   04100  SUBPROVI DER - 1 RF			0		41.00
42. 00   04200   SUBPROVI DER   42. 00   04200   SUBPROVI DER		•	0		42.00
ANCI LLARY SERVI CE COST CENTERS			0		42.00
54. 00   05400  RADI OLOGY-DI AGNOSTI C		0. 2663	25 43, 293	11, 530	54.00
57. 00   05700   CT   SCAN		0. 00000		0	1
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI)		0.00000			58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON		0.00000			59.00
60. 00   06000   LABORATORY		0. 30612		1	
60. 01   06001   BLOOD LABORATORY		0. 00000		24,002	60. 01
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000			1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 27380		1	
64. 00   06400   NTRAVENOUS THERAPY		0. 00000	· ·	1	64.00
66. 00   06600 PHYSI CAL THERAPY		0. 4321		1	1
69. 00   06900   ELECTROCARDI OLOGY		0. 0765	· ·		1
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS		0. 2857			
71. 30   07100   MEDICAL SUITETES CHARGED TO PATTENTS		0. 00000	· ·	20,034	71. 30
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0.00000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 55920		1	
76. 00   03030  ANGI OCARDI OGRAPHY		0. 00000	· ·		1
OUTPATIENT SERVICE COST CENTERS		0.0000	30  0	0	70.00
88. 00 08800 RURAL HEALTH CLINIC		0.0000	20	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89.00
90. 00   09000   CLINIC		0. 8305!		_	90.00
91. 00   09100   EMERGENCY		1. 3840		o o	91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		0. 8042		-	92.00
93. 00   04050   TELEMEDI CI NE		0. 00000		-	93. 00
OTHER REIMBURSABLE COST CENTERS		0.0000	50  5		70.00
95. 00 09500 AMBULANCE SERVI CES					95. 00
98. 00 09851 OTHER REIMBURSABLE COST CENTERS		0.0000	00	0	1
200.00 Total (sum of lines 50-94 and 96-98)			338, 923	126, 334	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)	/		338, 923	•	202. 00
		•		1	

Health Financial Systems	THOMAS H BOYD CRITICAL	ACC HOSPITAL		In Lie	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:	141300	Peri od: From 09/01/2014	Worksheet D-3

Component CCN: 14Z300 To 08/31/2015 Date/Time Prepared: 1/28/2016 9:46 am Title XVIII Swing Beds - SNF Cost Inpatient Inpati ent Cost Center Description Ratio of Cost To Charges Program Costs Program (col. 1 x col Charges 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 04000 SUBPROVI DER - I PF 40.00 40.00 41.00 04100 SUBPROVIDER - IRF 0 41.00 04200 SUBPROVI DER 42.00 42.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.266325 14, 370 3,827 54.00 57.00 05700 CT SCAN 0.000000 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0 58.00 0 05900 CARDI AC CATHETERI ZATI ON 59.00 0.000000 59.00 Λ 60.00 06000 LABORATORY 0.306124 51, 139 15, 655 60.00 60.01 06001 BLOOD LABORATORY 0.000000 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 273803 63.00 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 06600 PHYSI CAL THERAPY 0. 432134 66.00 125, 014 54,023 66.00 06900 ELECTROCARDI OLOGY 0.076576 69 00 43 69 00 564 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 285774 101, 201 28, 921 71.00 07101 IMPL. DEV. CHARGED TO PATIENT 0.000000 0 71.30 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 0.000000 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73 00 0.559202 127, 160 71, 108 73 00 03030 ANGI OCARDI OGRAPHY 76.00 0.000000 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0.000000 0 89.00 90.00 09000 CLI NI C 0.830554 0 90.00 09100 EMERGENCY 91.00 1.384095 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 0.804254 0 0 92.00 04050 TELEMEDI CI NE 93.00 0.000000 0 93.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 98. 00 09851 OTHER REIMBURSABLE COST CENTERS 0.000000 Ω 98.00 200.00 Total (sum of lines 50-94 and 96-98) 419, 448 173, 577 200. 00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 201.00 202.00 Net Charges (line 200 minus line 201) 419, 448 202.00

Health Financial Systems	THOMAS H BOYD CRITICAL A	ACC HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 141300	Period: From 09/01/2014	Worksheet E
				Date/Time Prepared:

			To 08/31/2015	Date/Time Pre 1/28/2016 9:4	
		Title XVIII	Hospi tal	Cost	o alli
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			1, 916, 960	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	2. 00
3.00	PPS payments			0	3. 00
4.00	Outlier payment (see instructions)			0	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct Line 2 times line 5	ions)		0. 000 0	5.00
6. 00 7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)			0.00	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			1, 916, 960	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	0 0.7		0	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for pa			0	15. 00
16. 00	Amounts that would have been realized from patients liable for	payment for services o	n a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0.000000	18.00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	19. 00
	instructions)		, ,		
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		1, 936, 130	21. 00
22. 00	Interns and residents (see instructions)	, , , , , , , , , , , , , , , , , , , ,		0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			15 100	25 00
25. 00 26. 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	CAH see instructions)		15, 192 524, 977	25. 00 26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl		and 231 (see	1, 395, 961	
	instructions)		0] (000	.,,	
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00 31. 00	Subtotal (sum of lines 27 through 29)			1, 395, 961 481	30. 00 31. 00
32.00	Primary payer payments Subtotal (line 30 minus line 31)			1, 395, 480	32.00
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		1, 0, 0, 100	02.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34. 00	Allowable bad debts (see instructions)			81, 670	34.00
35. 00	Adjusted reimbursable bad debts (see instructions)			62, 069	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	CTI ons)		77, 183	
	MSP-LCC reconciliation amount from PS&R			1, 457, 549 0	38.00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			1, 457, 549	40.00
40. 01	Sequestration adjustment (see instructions) Interim payments			29, 151	1
41. 00 42. 00	Tentative settlement (for contractors use only)			1, 259, 874 0	41. 00 42. 00
43. 00	Balance due provider/program (see instructions)			168, 524	43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR			0	00 00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
92. 00	The rate used to calculate the Time Value of Money			0.00	92. 00
93. 00	Time Value of Money (see instructions)			0	93. 00
94. 00	Total (sum of lines 91 and 93)			0	94. 00

1, 428, 398

NPR Date (Mo/Day/Yr)

2 00

7.00

8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 141300 Peri od: Worksheet E-1 From 09/01/2014 Part I 08/31/2015 Date/Time Prepared: 1/28/2016 9:46 am Title XVIII Hospi tal Cost Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 614, 320 1, 512, 066 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 03/23/2015 15, 837 0 3.01 08/19/2015 3.02 88, 924 0 3.02 3.03 3. 03 0 0 3.04 0 Ω 3.04 3.05 0 0 3.05 Provider to Program 03/23/2015 3.50 ADJUSTMENTS TO PROGRAM 105, 536 3.50 3.51 0 08/19/2015 146,656 3.51 0 3.52 0 3.52 0 3.53 0 3.53 3.54  $\cap$ Λ 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 104, 761 -252, 192 3.99 3.50-3.98) 719, 081 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1, 259, 874 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 168, 524 6.01 6 02 SETTLEMENT TO PROGRAM 128, 402 0 6.02

590, 679

0

Contractor

Number

1 00

7.00

8.00 Name of Contractor

Total Medicare program liability (see instructions)

Heal th Financial SystemsTHOMAS HANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 141300 | Peri od: | Worksheet E-1 | Part | | Date/Time Prepared: 1/28/2016 9: 46 am

					1/28/2016 9:4	o am
		Ti tl	e XVIII Sv	ving Beds - SNF	Cost	
		Inpatien	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1 00		1.00				1 00
1.00	Total interim payments paid to provider		818, 345		0	
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	00/00/0045				
3. 01	ADJUSTMENTS TO PROVIDER	03/23/2015	146, 017		0	
3.02		08/19/2015	246, 907		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3.04
3.05			0		0	3. 05
0.00	Provider to Program					0.00
2 50	ADJUSTMENTS TO PROGRAM		0		0	2 50
3.50	ADJUSTMENTS TO PROGRAM					
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		392, 924		0	3. 99
	3. 50-3. 98)		,			
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 211, 269		0	4.00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		1,211,207		Ĭ	1.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					1
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		l 0	5. 02
5.03			l o		0	5. 03
	Provider to Program					1
5. 50	TENTATI VE TO PROGRAM		0		0	5.50
	ILIVIATIVE TO FROURAWI		0		0	
5. 51			_		-	5. 51
5. 52			0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					1
6.01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		18, 047		0	
7. 00	Total Medicare program liability (see instructions)		1, 193, 222		0	
7.00	Total mearcare program trabitity (see instructions)		1, 175, 222	Contractor	NPR Date	7.00
				Contractor		
			2	Number	(Mo/Day/Yr)	
	To the second se		)	1. 00	2. 00	
8.00	Name of Contractor					8.00

Heal th F	Financial Systems THOMAS H BOYD CF	RITICAL ACC HOSPITAL	In Lie	eu of Form CMS-2	2552-10
CALCULAT	TION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 141300	Peri od: From 09/01/2014 To 08/31/2015		pared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
T	O BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPOR	TS			
<u>H</u> !	IEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCUL	ATI ON			
1.00 T	Total hospital discharges as defined in AARA §4102 from	Wkst. S-3, Pt. I col. 15 lir	ne 14	167	1. 00
2.00 M	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines	1, 8-12	ļ	294	2. 00
3.00 M	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			34	3. 00
4.00 T	Total inpatient days from S-3, Pt. I col. 8 sum of lines	: 1, 8-12	ļ	435	4. 00
5.00 T	Total hospital charges from Wkst C, Pt. I, col. 8 line 2	200	ļ	15, 125, 077	5. 00
6.00 T	Total hospital charity care charges from Wkst. S-10, col	. 3 line 20	ļ	144, 438	6. 00
7.00 C	CAH only - The reasonable cost incurred for the purchase	of certified HIT technology	/Wkst. S-2, Pt. I	859, 966	7. 00
1	ine 168		ļ		
8.00 C	Calculation of the HIT incentive payment (see instructio	ns)		826, 685	8. 00
9.00 S	Sequestration adjustment amount (see instructions)		ļ	16, 534	9. 00
10.00 C	Calculation of the HIT incentive payment after sequestra	ition (see instructions)	ļ	810, 151	10.00

inpatient Hospital Services Under the ipps & CAH

30.00 Initial/interim HIT payment adjustment (see instructions)

31.00 Other Adjustment (specify)

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

836, 380 30. 00 0 31. 00

-26, 229 32. 00

Health Financial Systems	THOMAS H BOYD CRITICA	ACC HOSPITAL	AL In Lieu of Form CMS-			
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 141300		Worksheet E-2		
		Component CCN: 14Z300	From 09/01/2014 To 08/31/2015			
				1/28/2016 9:46 am		

Title XVIII   Swing Beds - SNF			Component CCN: 14Z300	10 08/31/2015	Date/IIme Pre 1/28/2016 9:4	
1.00   2.00			Title XVIII	Swing Beds - SNF	Cost	
COMPUTATION OF NET COST OF COVERED SERVICES   Inpatient routine services - swing bed-SNF (see instructions)   1, 061, 597   0   1.00				Part A	Part B	
1.00   Inpatient routine services - swing bed-SNF (see instructions)   1,061,597   0   1.00				1. 00	2. 00	
2.00   Inpatient routine services - swing bed-NF (see instructions)						
3.00   Ancillary services (from Wkst. D-3, col. 3   line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)   175, 313   0   3.00	1.00			1, 061, 597	0	1. 00
Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)   Per diem cost for interns and residents not in approved teaching program (see instructions)   5.00   Program days   571   0   5.00     10   Interns and residents not in approved teaching program (see instructions)   0   6.00     10   Interns and residents not in approved teaching program (see instructions)   0   6.00     10   Interns and residents not in approved teaching program (see instructions)   0   6.00     10   Interns and residents not in approved teaching program (see instructions)   0   6.00     10   Interns and residents not in approved teaching program (see instructions)   0   6.00     10   Interns and residents not in approved teaching program (see instructions)   0   6.00     10   Interns and residents not in approved teaching program (see instructions)   0   6.00     10   Interns and residents not in approved teaching program (see instructions)   0   0   6.00     10   Interns and residents not in approved teaching program (see instructions)   0   0   0   0     10   Interns and residents not in approved teaching program (see instructions)   0   0   0   0   0   0     10   Subtotal (sum of lines 1 through 3 plus lines 6 and 7)   0   1,236,910   0   10   0     10   Deductibles billed to program patients (exclude amounts applicable to physician professional services)   0   11   00     10   Deductibles billed to program patients (exclude amounts applicable to physician professional services)   0   12   00     12   Deductibles billed to program patients (from provider records) (exclude coinsurance for physician professional services)   0   12   00     10   Subtotal (line 10 minus line 11)   1,236,910   0   12   00     10   Subtotal (line 12 x 80%)   0   14   00     10   Subtotal (enter the lesser of line 12 minus line 13, or line 14)   1,216,735   0   15   00     10   Subtotal (enter the lesser of line 12 minus line 13, or line 14)   1,216,735   0   16   00     10   Subtotal (enter the lesser of line 12 minus line 14)   1,216,7	2.00					2. 00
4.00 Per diem cost for interns and residents not in approved teaching program (see instructions)  5.00 Program days  6.00 Interns and residents not in approved teaching program (see instructions)  7.00 Utilization review - physician compensation - SNF optional method only  8.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7)  9.00 Primary payer payments (see instructions)  9.00 Primary payer payments (see instructions)  10.00 Subtotal (line 8 minus line 9)  11.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services)  12.00 Subtotal (line 10 minus line 11)  13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance of physician professional services)  14.00 80% of Part B costs (line 12 x 80%)  15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14)  15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14)  16.50 Pioneer ACO demonstration payment adjustment (see instructions)  10.10 Allowable bad debts (see instructions)  11.00 Allowable bad debts (see instructions)  12.01 Allowable bad debts (see instructions)  13.02 Cinsurance billed to gayment adjustment (see instructions)  14.03 On Allowable bad debts (see instructions)  15.05 Line 12 x 80%)  16.55 Allowable bad debts (see instructions)  17.00 Allowable bad debts (see instructions)  18.00 Allowable bad debts (see instructions)  19.00 Total (see instructions)  10.00 Internim payments  10.00 Internim payment	3.00			175, 313	0	3. 00
Instructions   Program days   571   0   5.00						
5.00         Program days'         571         0         5.00           6.00         Interns and residents not in approved teaching program (see instructions)         0         6.00           7.00         Utilization review - physician compensation - SMF optional method only         0         7.00           8.00         Subtotal (sum of lines 1 through 3 plus lines 6 and 7)         1, 236, 910         0         8.00           9.00         Primary payer payments (see instructions)         0         0, 9.00         0         9.00           10.00         Subtotal (line 8 minus line 9)         0         1, 236, 910         0         10.00           11.00         Deductibles billed to program patients (exclude amounts applicable to physician professional services)         0         11.00           12.00         Subtotal (line 10 minus line 11)         1, 236, 910         1, 236, 910         12.00           13.00         Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)         1, 236, 910         12.00           14.00         8.00         Part B costs (line 12 x 80%)         1, 236, 910         12.00           15.00         Subtotal (enter the lesser of line 12 minus line 13, or line 14)         1, 216, 735         0         15.00           16.50         Othick En	4.00		program (see		0.00	4. 00
6.00   Interns and residents not in approved teaching program (see instructions)						
7. 00   Utilization review - physician compensation - SNF optional method only   0   1, 236, 910   0   8. 00   0   9. 00   0   0   9. 00   0   0   0   0   0   0   0   0   0				571	0	
8.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 9.00 Primary payer payments (see instructions) 0 0 9.00 10.00 Subtotal (line 8 minus line 9) 11.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 12.00 Subtotal (line 10 minus line 11) 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 17.00 Allowable bad debts (see instructions) 18.00 Adjusted reimbursable bad debts (see instructions) 18.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 19.00 Total (see instructions) 19.00 Interim payments 10.20 Experiments (for onnal lowable cost report items) in accordance with CMS Pub. 15-2, 19.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 10.01 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 11.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 11.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 11.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 11.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 11.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 11.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 11.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 19.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 19.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 19.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 19.00 Protested amounts (					0	
9.00 Primary payer payments (see instructions) 10.00 Subtotal (line 8 minus line 9) 11.00 Deductible sbilled to program patients (exclude amounts applicable to physician professional services) 12.00 Subtotal (line 10 minus line 11) 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 Pioneer ACO demonstration payment adjustment (see instructions) 16.55 410A RURAL DEMONSTRATION PROJECT 17.00 Allowable bad debts (see instructions) 18.00 Allowable bad debts (see instructions) 19.01 Total (see instructions) 19.01 Sequestration adjustment (see instructions) 10.02 Subtotation adjustment (see instructions) 10.03 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 10.04 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 10.05 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 10.06 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 10.07 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 10.08 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 10.09 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 10.00 OTHER ADJUSTMENTS (SEE INS			l only	0		
10.00 Subtotal (line 8 minus line 9) 11.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 12.00 Subtotal (line 10 minus line 11) 12.00 Subtotal (line 10 minus line 11) 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 15.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 17.00 Allowable bad debts (see instructions) 18.00 Allowable bad debts (see instructions) 19.00 Total (see instructions) 19.00 Total (see instructions) 19.00 Total (see instructions) 10.00 Interim payments 10.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 10.00 Total (contact of the program (line 19 minus lines 19.01, 20, and 21) 10.00 Total (contact of the program (line 19 minus lines 19.01, 20, and 21) 10.00 Total (contact of the program (line 19 minus lines 19.01, 20, and 21) 10.00 Total (contact of the program (line 19 minus lines 19.01, 20, and 21) 10.00 Total (contact of the program (line 19 minus lines 19.01, 20, and 21) 10.00 Total (contact of the program (line 19 minus lines 19.01, 20, and 21) 10.00 Total (contact of the program (line 19 minus lines 19.01, 20, and 21) 10.00 Total (contact of the program (line 19 minus lines 19.01, 20, and 21) 10.00 Total (contact of the program (line 19 minus lines 19.01, 20, and 21) 10.00 Total (contact of the program (line 19 minus lines 19.01, 20, and 21) 10.00 Total (contact of the program (line 19 minus lines 19.01, 20, and 21) 10.00 Total (contact of the program (line 19 minus lines 19.01, 20, and 21) 10.01 Total (contact of the program (line 19 minus lines 19.01, 20, and 21) 10.01 Total (contact of the program (line 19 minus lines 19.01, 20, and 21) 10.01 Total (contact of the program (line 19 minus lines 19.01, 20, and 21) 10.02 Total (contact of the program (li		,		1, 236, 910	ū	
11. 00 Deductible's billed to program patients (exclude amounts applicable to physician professional services)  12. 00 Subtotal (line 10 minus line 11)  13. 00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)  14. 00 80% of Part B costs (line 12 x 80%)  15. 00 Subtotal (enter the lesser of line 12 minus line 13, or line 14)  15. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  16. 50 Pioneer ACO demonstration payment adjustment (see instructions)  17. 00 Allowable bad debts (see instructions)  18. 00 Allowable bad debts (see instructions)  19. 00 Total (see instructions)  10. 01 Total (see instructions)  11. 02 Equestration adjustment (see instructions)  10. 01 Total (see instructions)  11. 02 Equestration adjustment (see instructions)  10. 01 Total (see instructions)  11. 02 Equestration adjustment (for contractor use only)  12. 00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21)  11. 00 Interest payments  12. 00 Interest defined to program patients (exclude coinsurance and insurance				0	0	
professional services)  12.00 Subtotal (line 10 minus line 11)  12.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)  14.00 80% of Part B costs (line 12 x 80%)  15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14)  15.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  16.50 Pioneer ACO demonstration payment adjustment (see instructions)  17.00 Allowable bad debts (see instructions)  18.00 Allowable bad debts (see instructions)  19.00 Total (see instructions)  10.01 Sequestration adjustment (see instructions)  10.02 Total (see instructions)  10.03 Sequestration adjustment (see instructions)  10.04 Sequestration adjustment (see instructions)  10.05 Sequestration adjustment (see instructions)  10.06 Total (see instructions)  10.07 Total (see instructions)  10.08 Sequestration adjustment (see instructions)  10.09 Total (see instructions)  10.00 Total (see instructions)  10.01 Sequestration adjustment (see instructions)  10.01 Total (see instructions)  10.02 Total (see instructions)  10.03 Total (see instructions)  10.04 Total (see instructions)  10.05 Total (see instructions)  10.06 Total (see instructions)  10.07 Total (see instructions)  10.08 Total (see instructions)  10.09 Total (see instructions)  10.00 Total (see instructions)  10.01 Total (see instructions)  10.01 Total (see instructions)  10.02 Total (see instructions)  10.03 Total (see instructions)  10.04 Total (see instructions)  10.05 Total (see instructions)  10.07 Total (see instructions)  10.08 Total (see instructions)  10.09 Total (see instructions)  10.10 Total (see instructions)  10.10 Total (see instructions)  10.10 Total (see instructions)  10.10 Total (see instructions)				1, 236, 910	0	
12.00 Subtotal (line 10 minus line 11) 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 15.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 Pioneer ACO demonstration payment adjustment (see instructions) 17.01 Adjusted reimbursable bad debts (see instructions) 18.00 Allowable bad debts (see instructions) 19.00 Total (see instructions) 10.10 Allowable bad debts for dual eligible beneficiaries (see instructions) 10.10 Sequestration adjustment (see instructions) 10.11 Sequestration adjustment (see instructions) 10.12 On 12.00 Total (see instructions) 11.103 On 17.00 On 18.00 On 19.00	11. 00		e to physician	0	0	11. 00
13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)  14.00 80% of Part B costs (line 12 x 80%)  15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14)  15.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  16.50 Pioneer ACO demonstration payment adjustment (see instructions)  16.55 410A RURAL DEMONSTRATION PROJECT  17.00 Allowable bad debts (see instructions)  18.00 Adjusted reimbursable bad debts (see instructions)  19.00 Total (see instructions)  19.01 Sequestration adjustment (see instructions)  10.02 Cool Interim payments  10.03 Coinsurance 20, 175  10.14 (00  14.00  15.00  16.50  16.55  17.103  18.00  17.01  18.00  19.00 Total (see instructions)  10.103  11.103  11.103  12.17,573  12.17,573  13.00  14.00  15.00  17.01  18.00  18.00  19.01 Total (see instructions)  10.01 Interim payments  10.02 Cool Tentative settlement (for contractor use only)  22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21)  23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,						
for physician professional services)  14.00 80% of Part B costs (line 12 x 80%)  15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14)  15.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  17.00 Pioneer ACO demonstration payment adjustment (see instructions)  18.00 Allowable bad debts (see instructions)  19.00 Adjusted reimbursable bad debts (see instructions)  10.10 Adjusted reimbursable bad debts (see instructions)  10.10 Allowable bad debts for dual eligible beneficiaries (see instructions)  10.10 Total (see instructions)  10.10 Sequestration adjustment (see instructions)  10.10 Interim payments  11.211, 269  12.00 Tentative settlement (for contractor use only)  12.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21)  10.10 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,		,			0	
14. 00       80% of Part B costs (line 12 x 80%)       0       14. 00         15. 00       Subtotal (enter the lesser of line 12 minus line 13, or line 14)       1, 216, 735       0       15. 00         16. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       0       16. 00         16. 50       Pi oneer ACO demonstration payment adjustment (see instructions)       0       0       16. 50         16. 55       410A RURAL DEMONSTRATION PROJECT       0       16. 55         17. 01       All lowable bad debts (see instructions)       1, 103       0       17. 01         17. 01       Adjusted reimbursable bad debts (see instructions)       838       0       17. 01         18. 00       All lowable bad debts for dual eligible beneficiaries (see instructions)       1, 103       0       18. 00         19. 01       Total (see instructions)       1, 217, 573       0       19. 00         19. 01       Sequestration adjustment (see instructions)       24, 351       0       19. 01         20. 00       Interim payments       1, 211, 269       0       20. 00         21. 00       Tentative settlement (for contractor use only)       0       -18, 047       0       22. 00         23. 00       Protested amounts (nonallowable cost report items) in accordance wi	13. 00		exclude coinsurance	20, 175	0	13. 00
15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14)  16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  16.50 Pi oneer ACO demonstration payment adjustment (see instructions)  16.55 410A RURAL DEMONSTRATION PROJECT  17.00 Allowable bad debts (see instructions)  18.00 Allowable bad debts (see instructions)  19.00 Total (see instructions)  19.01 Sequestration adjustment (see instructions)  10.01 Interim payments  10.02 Dentative settlement (for contractor use only)  21.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21)  22.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,						
16.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       16.00         16.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       16.50         16.55       410A RURAL DEMONSTRATION PROJECT       0       16.55         17.00       Allowable bad debts (see instructions)       1,103       0       17.00         17.01       Adjusted reimbursable bad debts (see instructions)       838       0       17.01         18.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       1,103       0       18.00         19.01       Total (see instructions)       1,217,573       0       19.00         19.01       Sequestration adjustment (see instructions)       24,351       0       19.01         20.00       Interim payments       1,211,269       0       20.00         21.00       Tentative settlement (for contractor use only)       0       21.00         22.00       Balance due provider/program (line 19 minus lines 19.01, 20, and 21)       -18,047       0       22.00         23.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,       0       0       23.00						
16. 50       Pi oneer ACO demonstration payment adjustment (see instructions)       0       0       16. 50         16. 55       410A RURAL DEMONSTRATION PROJECT       0       16. 55         17. 00       All owable bad debts (see instructions)       1, 103       0       17. 00         17. 01       Adjusted reimbursable bad debts (see instructions)       838       0       17. 01         18. 00       All owable bad debts for dual eligible beneficiaries (see instructions)       1, 103       0       18. 00         19. 00       Total (see instructions)       1, 217, 573       0       19. 00         19. 01       Sequestration adjustment (see instructions)       24, 351       0       19. 00         20. 00       Interim payments       1, 211, 269       0       20. 00         21. 00       Tentative settlement (for contractor use only)       0       0       21. 00         22. 00       Balance due provider/program (line 19 minus lines 19. 01, 20, and 21)       -18, 047       0       22. 00         23. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,       0       0       23. 00				1, 216, 735	0	
16. 55       410A RURAL DEMONSTRATION PROJECT       0       16. 55         17. 00       Allowable bad debts (see instructions)       1, 103       0       17. 00         17. 01       Adjusted reimbursable bad debts (see instructions)       838       0       17. 01         18. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       1, 103       0       18. 00         19. 00       Total (see instructions)       1, 217, 573       0       19. 00         19. 01       Sequestration adjustment (see instructions)       24, 351       0       19. 01         20. 00       Interim payments       1, 211, 269       0       20. 00         21. 00       Tentative settlement (for contractor use only)       0       0       21. 00         22. 00       Balance due provider/program (line 19 minus lines 19. 01, 20, and 21)       -18, 047       0       22. 00         23. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,       0       0       23. 00				0	-	
17. 00       Allowable bad debts (see instructions)       1, 103       0       17. 00         17. 01       Adjusted reimbursable bad debts (see instructions)       838       0       17. 01         18. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       1, 103       0       18. 00         19. 00       Total (see instructions)       1, 217, 573       0       19. 00         19. 01       Sequestration adjustment (see instructions)       24, 351       0       19. 01         20. 00       Interim payments       1, 211, 269       0       20. 00         21. 00       Tentative settlement (for contractor use only)       0       0       21. 00         22. 00       Balance due provider/program (line 19 minus lines 19. 01, 20, and 21)       -18, 047       0       22. 00         23. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,       0       0       23. 00				0	0	
17. 01 Adjusted reimbursable bad debts (see instructions) 18. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 19. 00 Total (see instructions) 19. 01 Sequestration adjustment (see instructions) 20. 00 Interim payments 21. 00 Tentative settlement (for contractor use only) 22. 00 Balance due provider/program (line 19 minus lines 19. 01, 20, and 21) 23. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 17. 01 1, 103 1, 103 1, 103 1, 103 1, 217, 573 0 19. 00 19. 01 19.				0		1
18.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       1, 103       0       18.00         19.00       Total (see instructions)       1, 217, 573       0       19.00         19.01       Sequestration adjustment (see instructions)       24, 351       0       19.01         20.00       Interim payments       1, 211, 269       0       20.00         21.00       Tentative settlement (for contractor use only)       0       0       21.00         22.00       Balance due provider/program (line 19 minus lines 19.01, 20, and 21)       -18,047       0       22.00         23.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,       0       0       23.00					0	
19.00       Total (see instructions)       1, 217, 573       0       19.00         19.01       Sequestration adjustment (see instructions)       24, 351       0       19.01         20.00       Interim payments       1, 211, 269       0       20.00         21.00       Tentative settlement (for contractor use only)       0       0       21.00         22.00       Balance due provider/program (line 19 minus lines 19.01, 20, and 21)       -18,047       0       22.00         23.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,       0       0       23.00					0	
19.01     Sequestration adjustment (see instructions)     24,351     0 19.01       20.00     Interim payments     1,211,269     0 20.00       21.00     Tentative settlement (for contractor use only)     0 21.00       22.00     Balance due provider/program (line 19 minus lines 19.01, 20, and 21)     -18,047     0 22.00       23.00     Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,     0 0 23.00			i ons)		0	•
20.00 Interim payments 1,211,269 0 20.00 21.00 Tentative settlement (for contractor use only) 0 21.00 22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 23.00		· · · · · · · · · · · · · · · · · · ·			0	1
21.00 Tentative settlement (for contractor use only) 22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 21.00 -18,047 0 22.00 23.00					0	
22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 22.00 23.00				1, 211, 269	0	
23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 23.00	21. 00			0	0	
				-18, 047	0	
chapter 1, §115.2	23. 00		with CMS Pub. 15-2,	0	0	23. 00
		chapter 1, §115.2				

Health Financial Systems	THOMAS H BOYD CRITICAL	ACC HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141300	From 09/01/2014	Worksheet E-3 Part V Date/Time Prepared: 1/28/2016 9:46 am
		Title XVIII	Hospi tal	Cost

				1/28/2016 9: 4	6 am
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR V - CALCULATION OF REIMBURSEME	ART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpati ent servi ces			667, 523	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	5)		0	2.00
3. 00	Organ acqui si ti on	2)		0	3. 00
4. 00	Subtotal (sum of lines 1 through 3)			667, 523	
5. 00	Primary payer payments			007,020	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			674, 198	
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			074, 170	0.00
	Reasonable charges				
7. 00	Routi ne servi ce charges			0	7. 00
8.00	Ancillary service charges			0	8.00
9.00	1			0	
	Organ acquisition charges, net of revenue				
10. 00	Total reasonable charges			0	10. 00
44 00	Customary charges		1 1 1		44 00
11.00	Aggregate amount actually collected from patients liable for pa			_	11. 00
12. 00	Amounts that would have been realized from patients liable for	payment for services o	n a charge basis	0	12. 00
40.00	had such payment been made in accordance with 42 CFR 413.13(e)				40.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	
14.00	Total customary charges (see instructions)		() (	0	
15. 00	Excess of customary charges over reasonable cost (complete only	IT line 14 exceeds li	ne 6) (see	0	15. 00
47.00	instructions)		4.4) (		47.00
16. 00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds lin	e 14) (see	0	16. 00
47.00	instructions)				47.00
17.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			_	
18. 00	Direct graduate medical education payments (from Worksheet E-4,	line 49)			18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			674, 198	
20. 00	Deductibles (exclude professional component)			94, 704	
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			579, 494	
23. 00	Coi nsurance			0	
24. 00	Subtotal (line 22 minus line 23)			579, 494	
25. 00	Allowable bad debts (exclude bad debts for professional service	s) (see instructions)		30, 579	
26. 00	Adjusted reimbursable bad debts (see instructions)			23, 240	
27.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		26, 082	
28.00	Subtotal (sum of lines 24 and 25, or line 26)			602, 734	28. 00
29. 00	NET MSP PAYMENTS			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 99	Recovery of Accelerated Depreciation			0	29. 99
30.00	Subtotal (see instructions)			602, 734	30. 00
30. 01	Sequestration adjustment (see instructions)	12, 055	30. 01		
31.00	Interim payments			719, 081	31. 00
32.00	Tentative settlement (for contractor use only)			0	
33. 00	Balance due provider/program (line 30 minus lines 30.01, 31, an	d 32)		-128, 402	33. 00
34.00	Protested amounts (nonallowable cost report items) in accordance		chapter 1,	0	
	§115. 2				
			·	-	-

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

Provider CCN: 141300 Period: From 09/01/2

Period: Worksheet G From 09/01/2014 To 08/31/2015 Date/Time Prepared: 1/28/2016 9:46 am

					1/28/2016 9: 4	6 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
		1. 00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-349, 999	0	0	0	1.00
2.00	Temporary investments	43, 015	0	0	0	2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	3, 297, 182	0	0	0	4. 00
5.00	Other recei vable	380, 359	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-1, 718, 083	0	o	0	6. 00
7.00	Inventory	24, 927		ol	0	7. 00
8. 00	Prepaid expenses	34, 224		أم	0	•
9. 00	Other current assets	49, 245		أم	0	9. 00
10.00	Due from other funds	0		Ö	0	10.00
11. 00	Total current assets (sum of lines 1-10)	1, 760, 870		-	0	11. 00
11.00	FIXED ASSETS	1, 700, 070	10	<u> </u>		11.00
12. 00	Land	70, 513	0	0	0	12. 00
13. 00				o	0	•
	Land improvements	36, 143		0	-	
14. 00	Accumulated depreciation	-36, 143		U	0	•
15.00	Bui I di ngs	2, 544, 975		U	0	15. 00
16. 00	Accumulated depreciation	-2, 335, 453		O <sub>1</sub>	0	16.00
17. 00	Leasehold improvements	0	0	O <sub>1</sub>	0	17. 00
18. 00	Accumul ated depreciation	0	0	0	0	18. 00
19. 00	Fi xed equipment	84, 028		0	0	19. 00
20.00	Accumul ated depreciation	-82, 302		0	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23.00	Major movable equipment	3, 065, 922	0	0	0	23. 00
24.00	Accumul ated depreciation	-2, 332, 676	0	0	0	24. 00
25.00	Mi nor equi pment depreci abl e	0	0	o	0	25. 00
26.00	Accumulated depreciation	l 0	0	ol	0	26. 00
27.00	HIT designated Assets	0	0	o	0	27. 00
28. 00	Accumulated depreciation	0	0	ol	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	ol	0	•
30.00	Total fixed assets (sum of lines 12-29)	1, 015, 007	Ö		0	
00.00	OTHER ASSETS	1,010,007		<u>ا</u>		00.00
31. 00	Investments	0	0	ol	0	31. 00
32. 00	Deposits on Leases	1	0	Ö	0	32. 00
33. 00	Due from owners/officers				0	33. 00
			0	0	0	ł
34.00	Other assets			٥	-	34.00
35. 00	Total other assets (sum of lines 31-34)	0 775 077	0	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	2, 775, 877	0	0	0	36. 00
	CURRENT LI ABI LI TI ES	1 000 000		ام		
37. 00	Accounts payable	1, 380, 092			0	•
38. 00	Salaries, wages, and fees payable	689, 236		0	0	38. 00
39. 00	Payroll taxes payable	80, 533		0	0	39. 00
40. 00	Notes and Loans payable (short term)	218, 054	0	0	0	40. 00
41. 00	Deferred income	0	0	0	0	41. 00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	18, 545	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2, 386, 460	0	0	0	45. 00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	696, 491	0	o	0	47. 00
48.00	Unsecured Loans	0	0	o	0	48. 00
49.00	Other long term liabilities	55, 170	0	ol	0	1
50. 00	Total long term liabilities (sum of lines 46 thru 49	751, 661		o	0	•
51. 00	Total liabilites (sum of lines 45 and 50)	3, 138, 121			0	1
01.00	CAPITAL ACCOUNTS	0, 100, 121		٩		01.00
52. 00	General fund balance	-362, 244				52. 00
53. 00	Specific purpose fund	302, 244	0			53.00
54. 00	Donor created - endowment fund balance - restricted			۸		54. 00
						•
55. 00	Donor created - endowment fund balance - unrestricted			ا ا		55.00
56. 00	Governing body created - endowment fund balance				_	56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
FO 05	replacement, and expansion	0.0.5	_	_	=	F0 00
59. 00	Total fund balances (sum of lines 52 thru 58)	-362, 244		0	0	•
60. 00	Total liabilities and fund balances (sum of lines 51 and	2, 775, 877	0	이	0	60. 00
	[59]	I	I			l

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES THOMAS H BOYD CRITICAL ACC HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 141300 Peri od: Worksheet G-1 From 09/01/2014 To 08/31/2015 Date/Time Prepared: 1/28/2016 9:46 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) -1, 265, 694 903, 450 1. 00 1.00 0 2.00 2.00 3. 00 3.00 Total (sum of line 1 and line 2) -362, 244 0

4.00

5.00

6.00

7. 00

8.00

9. 00

10.00

0

0

0

0

0

11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0 0 0 0	-362, 244 0 -362, 244	0 0 0 0 0	0 0 0	13. 00 14. 00 15. 00 16. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund		
		6. 00	7. 00	8. 00		
1. 00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3. 00 4. 00	Total (sum of line 1 and line 2)	U		0		3. 00 4. 00
4. 00 5. 00	Additions (credit adjustments) (specify)		0			5. 00
6. 00			0			6.00
7. 00			0			7. 00
8. 00			Ö			8.00
9. 00			Ö			9. 00
10.00	Total additions (sum of line 4-9)	o		0		10.00
11. 00	Subtotal (line 3 plus line 10)	o		0		11. 00
12.00	Deductions (debit adjustments) (specify)		0			12. 00
13.00			0			13. 00
14. 00			0			14. 00
15. 00			0			15. 00
16.00			0			16.00
17. 00 18. 00	Total deductions (sum of lines 12-17)		٥	0		17. 00 18. 00
19. 00	Fund balance at end of period per balance			0		19.00
17.00	sheet (line 11 minus line 18)					17.00
	10.001 (	1 I	'	I	I	1

4.00

5.00

6.00

7.00

8.00

9.00

Additions (credit adjustments) (specify)

10.00 Total additions (sum of line 4-9)

			10	00/31/2013	1/28/2016 9: 40	
	Cost Center Description	11	npati ent	Outpati ent	Total	J Cilli
			1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>				
	General Inpatient Routine Services					
1.00	Hospi tal		470, 131		470, 131	1.00
2.00	SUBPROVI DER - I PF		0		0	2.00
3.00	SUBPROVI DER - I RF		0		0	3.00
4.00	SUBPROVI DER		0		0	4.00
5.00	Swing bed - SNF		242, 085		242, 085	5.00
6.00	Swing bed - NF		0		0	6.00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY		0		0	8.00
9.00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)		712, 216		712, 216	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT					11. 00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of li	nes	0		0	16. 00
17 00	11-15)		710 014		710 01/	17 00
17. 00 18. 00	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services		712, 216 981, 162	720, 385	712, 216 1, 701, 547	
19.00	Outpatient services		961, 162			19. 00
20. 00	RURAL HEALTH CLINIC		0	10, 335, 227	10, 335, 227	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	2, 062, 159 0	2, 062, 159 0	20.00
	·		U	٩	U	
22. 00 23. 00	HOME HEALTH AGENCY		0	1 277 207	1 277 207	22. 00 23. 00
	AMBULANCE SERVI CES		U	1, 277, 206	1, 277, 206	24. 00
24. 00 24. 10	CMHC CORF		0	o	0	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )		0	0	0	25. 00
26. 00	HOSPICE		U	٩	U	26. 00
27. 00	OTHER (SPECIFY)		0		0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst	1, 693, 378	14, 394, 977	16, 088, 355	
20.00	G-3, line 1)	WKSt.	1, 073, 370	14, 374, 777	10, 000, 333	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			10, 630, 431		29. 00
30. 00	BAD DEBTS		591, 625	, ,		30. 00
31. 00	INTEREST EXPENSE		60, 444			31. 00
32. 00	HEALTHLINK FEES - RHC WHITE HALL		1, 294			32. 00
33. 00	HEALTHLINK FEES - HOSPITAL		13, 905			33. 00
34. 00			0			34. 00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)			667, 268		36. 00
37. 00	DEDUCT (SPECIFY)		0			37. 00
38. 00			0			38. 00
39. 00		1	Ö			39. 00
40. 00			O			40. 00
41. 00			O			41. 00
42. 00	Total deductions (sum of lines 37-41)	1	٦	0		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(	transfer		11, 297, 699		43. 00
	to Wkst. G-3, line 4)	[				
		•			•	

Heal th	Financial Systems THOMAS H BOYD CRITICAL	ACC HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 141300	Peri od:	Worksheet G-3	
01711211	THE THE PROPERTY OF THE PARTY O		From 09/01/2014	nor nonect o o	
			To 08/31/2015		
				1/28/2016 9: 4	6 am
				4.00	
1 00	T + 1	202		1.00	4 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			16, 088, 355	•
2.00	Less contractual allowances and discounts on patients' accounts			5, 491, 709	2.00
3.00	Net patient revenues (line 1 minus line 2)			10, 596, 646	ł
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	)		11, 297, 699	•
5.00	Net income from service to patients (line 3 minus line 4)			-701, 053	5. 00
	OTHER I NCOME		1		
6.00	Contributions, donations, bequests, etc			111, 657	1
7. 00	Income from investments			13, 109	•
8. 00	Revenues from telephone and other miscellaneous communication s	ervi ces		0	8. 00
9. 00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	1
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			32, 942	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 tha	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			5, 867	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			-4, 021	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
	WELL CTR/AMB/NON-REIMB/GAIN LOSS/EHR			1, 444, 949	1
25.00				1 (04 502	

1, 604, 503

903, 450

25.00

26.00

0 27.00

0 28.00 903, 450 29. 00

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

27. 00 OTHER EXPENSES (SPECIFY)

Health Financial Systems	THOMAS H BOYD CRITICAL A	CC HOSPITAL	<u>_</u>	In Lie	eu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RURAL HEAL	LTH CLINIC/FEDERALLY QUALIFIED	Provider CC	CN: 141300	Peri od:	Worksheet M-1
HEALTH CENTER COSTS				From 09/01/2014	
		Component C	CCN: 143403	To 08/31/2015	Date/Time Prepared:

			Component	t CCN: 143403		Date/Time Prepared: 1/28/2016 9:46 am	
					Rural Health Clinic (RHC) I	Cost	
		Compensation	Other Costs		1 Reclassi fi cati	Reclassi fied	
				+ col . 2)	ons	Trial Balance (col. 3 + col.	
						4)	
		1.00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS			'			
1.00	Physi ci an	669, 612	32, 152			635, 793	1.00
2.00	Physician Assistant	7, 557	221			7, 778	2.00
3.00	Nurse Practitioner	294, 288	12, 392	306, 68	0	306, 680	3. 00
4.00	Visiting Nurse	0 0 577	10.000	0/4 40	0	0	4.00
5. 00 6. 00	Other Nurse Clinical Psychologist	250, 577	10, 823	261, 40	0	261, 400 0	5. 00 6. 00
7. 00	Clinical Social Worker	0	0		0 0	0	7. 00
8. 00	Laboratory Techni ci an		0		0 0	0	8. 00
9. 00	Other Facility Health Care Staff Costs	Ö	8, 402	8, 40	2 0	8, 402	9. 00
10.00	Subtotal (sum of lines 1 through 9)	1, 222, 034	63, 990			1, 220, 053	10. 00
11. 00	Physician Services Under Agreement	o	0		0	0	11.00
12.00	Physician Supervision Under Agreement	0	7, 500	7, 50	0 0	7, 500	12.00
13.00	Other Costs Under Agreement	0	0	)	0	0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	7, 500			7, 500	14. 00
15. 00	Medical Supplies	0	27, 430	27, 43	0	27, 430	15.00
16. 00 17. 00	Transportation (Health Care Staff) Depreciation-Medical Equipment	0	0		0	0	16. 00 17. 00
18. 00	Professional Liability Insurance		0		0 0	0	18.00
19. 00	Other Health Care Costs	ol ol	0		0 1, 661	1, 661	19. 00
20. 00	Allowable GME Costs	Ö	0	,	0 0	0	20. 00
21. 00	Subtotal (sum of lines 15 through 20)	o	27, 430	27, 43	0 1, 661	29, 091	21.00
22. 00	Total Cost of Health Care Services (sum of	1, 222, 034	98, 920	1, 320, 95	-64, 310	1, 256, 644	22. 00
	lines 10, 14, and 21)						
22.00	COSTS OTHER THAN RHC/FQHC SERVICS			1		0	22.00
23. 00 24. 00	Pharmacy Dental	0	0		0	0	23. 00 24. 00
25. 00	Optometry		0		0 0	0	25. 00
26. 00	All other nonreimbursable costs	Ö	0		0 0	Ö	26. 00
27. 00	Nonallowable GME costs	Ö	0	,	0 0	Ō	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	o	0	)	0 0	0	28. 00
	through 27)						
	FACILITY OVERHEAD	ا		1	al	0.000	
29. 00	Facility Costs	0 170, 919	78, 267	249, 18	0 2, 000 6 -187, 110		29. 00 30. 00
30. 00 31. 00	Administrative Costs Total Facility Overhead (sum of lines 29 and	170, 919	78, 267 78, 267				30.00
31.00	30)	170, 919	10, 201	249, 18	-100, 110	04, 0/6	31.00
32. 00	Total facility costs (sum of lines 22, 28	1, 392, 953	177, 187	1, 570, 14	-249, 420	1, 320, 720	32. 00
	and 31)						

Health Financial Systems	THOMAS H [	BOYD CRITICAL	ACC HOSPIT	AL			In Lie	u of Form C	CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CENTER COSTS	HEALTH CLINIC/FEDERALLY	QUALI FI ED	Provi der	CCN:	141300		od: 09/01/2014	Worksheet	M-1
HEALTH CENTER COSTS			Component	CCN:	143403		08/31/2015		
						Rur	al Health	Co	st

				Clinic (RHC) I	
		Adjustments	Net Expenses	OFFINE (MIO) T	
			for Allocation		
			(col. 5 + col.		
			6)		
		6. 00	7. 00	1	
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physi ci an	0	635, 793	3	1.00
2.00	Physici an Assistant	0	7, 778		2. 00
3.00	Nurse Practitioner	0	306, 680		3. 00
4.00	Visiting Nurse	0	0		4. 00
5. 00	Other Nurse	0	261, 400		5. 00
6.00	Clinical Psychologist	0	0		6. 00
7. 00	Clinical Social Worker	0	0		7. 00
8. 00	Laboratory Techni ci an	0	0		8. 00
9. 00	Other Facility Health Care Staff Costs	0	8, 402		9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 220, 053		10.00
11. 00	Physician Services Under Agreement	0	1, 220, 033	l e e e e e e e e e e e e e e e e e e e	11. 00
12. 00	Physician Supervision Under Agreement	0	7, 500		12.00
13. 00	Other Costs Under Agreement	0	7,300	i e e e e e e e e e e e e e e e e e e e	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	7, 500		14. 00
15. 00	Medical Supplies	0	27, 430		15. 00
16. 00	Transportation (Health Care Staff)	0	27, 430		16. 00
17. 00	Depreciation-Medical Equipment	0		1	17. 00
18. 00	Professional Liability Insurance	0	0	l e e e e e e e e e e e e e e e e e e e	18.00
19. 00	Other Health Care Costs	1, 294		1	19.00
20. 00	Allowable GME Costs	1, 274	2, 755	i e	20.00
21. 00	Subtotal (sum of lines 15 through 20)	1, 294	-	1	21.00
22. 00	Total Cost of Health Care Services (sum of	1, 294		·	22. 00
22.00	lines 10, 14, and 21)	1, 274	1, 257, 750		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23. 00	Pharmacy	0	0		23. 00
24. 00	Dental	0	0	i de la companya del companya de la companya de la companya del companya de la co	24. 00
25. 00	Optometry	0	0		25. 00
26. 00	All other nonreimbursable costs	0	0		26. 00
27. 00	Nonallowable GME costs	0	0		27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		28. 00
	through 27)	_	_		
	FACILITY OVERHEAD		•		
29. 00	Facility Costs	0	2, 000		29. 00
30.00	Administrative Costs	0	62, 076		30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	64, 076	I and the second	31.00
	30)	_			
32.00	Total facility costs (sum of lines 22, 28	1, 294	1, 322, 014		32. 00
	and 31)				

ALLOCA	TION OF OVERHEAD TO RHC/FQHC SERVICES		Provi der		Peri od:	Worksheet M-2	
			Component		From 09/01/2014 To 08/31/2015	Date/Time Prep 1/28/2016 9:40	
					Rural Health Clinic (RHC) I	Cost	
		Number of FTE	Total Visits	Producti vi ty	/ Minimum Visits	Greater of	
		Personnel			(col. 1 x col. 3)		
		1.00	2. 00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1. 00	Physi ci an	1. 32					1.00
2. 00	Physician Assistant	0. 84					2.00
3. 00	Nurse Practitioner	1. 64					3.00
4. 00	Subtotal (sum of lines 1 through 3)	3. 80		1	10, 752	14, 943	
5. 00	Visiting Nurse	0. 00				0	
6. 00	Clinical Psychologist	0. 00				0	6. 00
7.00	Clinical Social Worker	0.00				0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	
7. 02	Diabetes Self Management Training (FQHC	0. 00	0			0	7. 02
8. 00	only) Total FTEs and Visits (sum of lines 4	3. 80	14, 943			14, 943	8.00
3.00	through 7)	3. 60	14, 743			14, 743	0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
,, 00	The oral controls that high coments						71.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	RHC/FQHC SERV	'I CES				
10.00	Total costs of health care services (from Wks	st. M-1, col. 7	7, line 22)			1, 257, 938	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	11.00
12.00	Cost of all services (excluding overhead) (se	um of lines 10	and 11)			1, 257, 938	12.00
13. 00	Ratio of RHC/FQHC services (line 10 divided					1.000000	13.00
14. 00	Total facility overhead - (from Wkst. M-1, co					64, 076	
15. 00					675, 864		
16. 00	Total overhead (sum of lines 14 and 15)					739, 940	
17. 00	,						17.00
	Subtotal (see instructions)		_			739, 940	
19. 00						739, 940	
20. 00	Total allowable cost of RHC/FQHC services (si	um of lines 10	and 19)			1, 997, 878	1 20.00

<u>Heal</u> th	Financial Systems THOMAS H BOYD CRITICAL	L ACC HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FOHC SERVICES	Provi der CCN: 141300	Peri od:	Worksheet M-3	
		Component CCN: 143403	From 09/01/2014 To 08/31/2015	Date/Time Prep 1/28/2016 9:40	
		Title XVIII	Rural Health Clinic (RHC) I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, lir			1, 997, 878	
2.00	Cost of vaccines and their administration (from Wkst. M-4, lir	ne 15)		16, 053	
3. 00 4. 00	Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Wkst. M-2, column 5, line 8)			1, 981, 825 14, 943	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		14, 943	
6. 00	Total adjusted visits (line 4 plus line 5)	1116 9)		14. 943	
7. 00	Adjusted cost per visit (line 3 divided by line 6)			132. 63	
			Cal cul ati on	of Limit (1)	
			Prior to	On on After	
			January 1	January 1	
			1. 00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	999. 00	999.00	
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		132. 63	132. 63	9.00
10.00	Program covered visits excluding mental health services (from	contractor records)	1, 329	2, 795	10.00
11.00	Program cost excluding costs for mental health services (line	9 x line 10)	176, 265	370, 701	11. 00
12. 00	Program covered visits for mental health services (from contra		0	0	
13. 00	Program covered cost from mental health services (line 9 x lin		0	-	13. 00
14.00	Limit adjustment for mental health services (see instructions)		0	0	
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instructions Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			0 546, 966	
16. 00	Total program charges (see instructions) (from contractor's rec			578, 238	
16. 02	Total program preventive charges (see instructions)(from provi			0,0,200	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			0	16. 03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 (Titles V and XIX see instructions.)	3 and 18) times .80)		380, 861	16. 04
16. 05	Total program cost (see instructions)			380, 861	
17. 00	Pri mary payer amounts			0	
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)			70, 890	
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		101, 470	19.00
20. 00	Net Medicare cost excluding vaccines (see instructions)			380, 861	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)			21. 00
22. 00	Total reimbursable Program cost (line 20 plus line 21)			389, 109	
23. 00	Allowable bad debts (see instructions)			22, 897	
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	suctions)		17, 402 22, 304	
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	uctions)		22, 304	
25. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	
26. 00	Net reimbursable amount (see instructions)			406, 511	
26. 01	Sequestration adjustment (see instructions)			8, 130	26. 01
27. 00	1 3			407, 558	27. 00
28. 00	Tentative settlement (for contractor use only)			0	
29. 00	Balance due component/program (line 26 minus lines 26.01, 27,	•		-9, 177	1
30.00	Protested amounts (nonallowable cost report items) in accordan	ice with CMS Pub. 15-II,		0	30.00

Health Financial Systems	THOMAS H BOYD CRITICAL	ACC HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VAC	CINE COST	Provider CCN: 141300		Worksheet M-4	
			From 09/01/2014		
		Component CCN: 143403	To 08/31/2015	Date/Time Pre	pared:
				1/28/2016 9: 4	6 am
		Title XVIII	Rural Health	Cost	
			Clinic (RHC) I		
			Pneumococcal	I nfl uenza	
			1 00	2 00	

		Clinic (RHC) I		
		Pneumococcal	I nfl uenza	
		1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1, 220, 053	1, 220, 053	1. 00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0. 000078	0. 005287	2. 00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	95	6, 450	3. 00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	55	3, 508	4. 00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	150	9, 958	5. 00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1, 257, 938	1, 257, 938	6. 00
7.00	Total overhead (from Wkst. M-2, line 16)	739, 940	739, 940	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5	0. 000119	0. 007916	8. 00
	divided by line 6)			
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	88	5, 857	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of	238	15, 815	10. 00
	lines 5 and 9)			
11. 00	Total number of pneumococcal and influenza vaccine injections (from your records)	5		11. 00
12. 00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	47. 60	50. 05	12. 00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program	4	161	13. 00
	benefi ci ari es			
14. 00	Program cost of pneumococcal and influenza vaccine and its (their) administration	190	8, 058	14. 00
	(line 12 x line 13)			
15. 00			16, 053	15. 00
4, 00	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		0.040	4, 00
16. 00	Total Program cost of pneumococcal and influenza vaccine and its (their)		8, 248	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,			
	line 21)			

Health Financial Systems	THOMAS H BOYD CRIT	CAL ACC HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RENDERED TO PROGRAM BENEFICIARIES	RHC/FQHC PROVI DER FOR SERV	CES Provider CCN: 141300	Peri od: From 09/01/2014	Worksheet M-5
RENDERED TO FROGRAM BENEFICIARIES		Component CCN: 143403		
			Rural Health	Cost

				17 207 2010 7. 40	o am
			Rural Health	Cost	
			Clinic (RHC) I		
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to provider			324, 180	1. 0
2. 00	Interim payments payable on individual bills, either submitte	ed or to be submitted to		ol	2.0
	the contractor for services rendered in the cost reporting pe	eriod. If none, write			
	"NONE" or enter a zero				
. 00	List separately each retroactive lump sum adjustment amount b	based on subsequent			3. (
	revision of the interim rate for the cost reporting period. A	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01	- V		03/23/2015	5, 739	3. (
3. 02			03/23/2015	23, 635	3.0
. 03			03/23/2015	18, 972	3. (
3. 04			08/19/2015	35, 032	3. (
. 05				0	3. (
	Provider to Program			_	
. 50				0	3.
. 51				0	3.
. 52				Ö	3.
. 53				0	3.
. 54				0	3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98	8)		83, 378	3.
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer			407, 558	4.
. 00	27)	or to worksheet in o, Time		107, 000	
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after desk	review Also show date of	2		5.
	each payment. If none, write "NONE" or enter a zero. (1)				0.
	Program to Provider				
. 01				0	5.
. 02				0	5.
. 03				Ö	5.
. 00	Provider to Program			0	
. 50	1 Tovi doi: to 11 ogi diii			0	5.
. 51				Ö	5.
. 52				ol	5.
. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98	8)		0	5.
. 00	Determined net settlement amount (balance due) based on the			١	6.
. 00	SETTLEMENT TO PROVIDER	cost report. (1)		0	6.
. 01	SETTLEMENT TO PROVIDER			9, 177	6.
				9, 177 398, 381	
. 00	Total Medicare program liability (see instructions)		Contract	NPR Date	7.
			Contractor		
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	